A Manual for Psychiatric Case Study

SECOND EDITION

By KARL A. MENNINGER, M.D.

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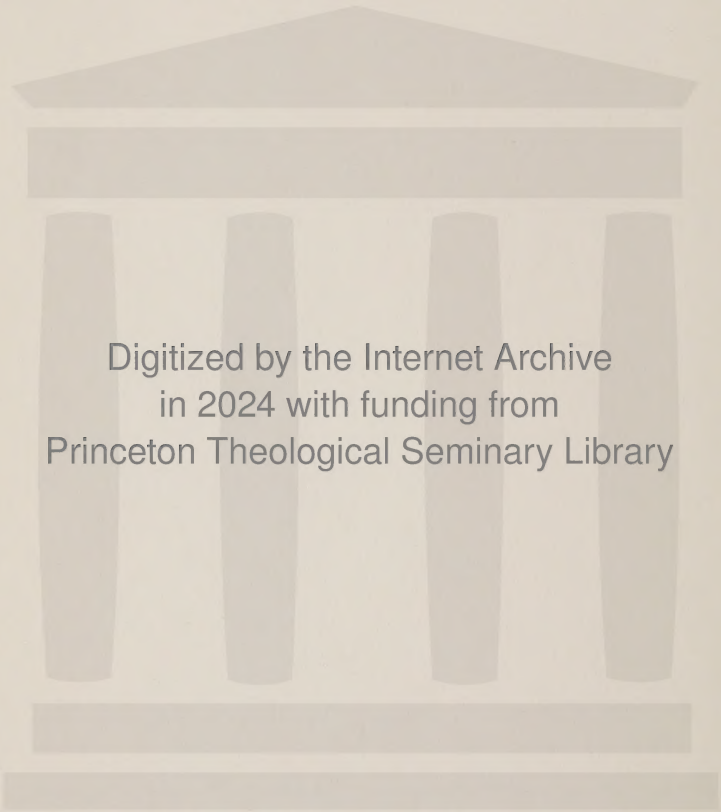
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A Manual for Psychiatric Case Study

SECOND EDITION

With a series of Illustrative Forms for use in
Examination, Diagnosis, and Planning and Charting Treatment

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THE MENNINGER CLINIC MONOGRAPH SERIES • No. 8

A Manual for Psychiatric Case Study

SECOND EDITION

By KARL A. MENNINGER, M.D.

with MARTIN MAYMAN, Ph.D.

and PAUL W. PRUYSER, Ph.D.

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Preface

THIS *Manual* was originally written for the guidance of doctors entering the field of psychiatry. Its purpose was to supply a plan of procedure for the study of psychiatric patients and for the recording of clinical data in a way which could lead to useful conclusions and recommendations.

It would go beyond the purview of this preface to discuss which individuals come to psychiatrists and how and why. That they are doing so in increasing numbers is common knowledge. It is the responsibility of the psychiatrist to make certain investigations, certain conclusions so that he can make certain recommendations. It is the function of this *Manual* to guide him in this process of case study.

This is a world of change. Techniques change, facts change, situations change. Likewise concepts change, concepts of illness, of personality, of diagnosis. They have all changed since the first edition of this *Manual* ten years ago. Some trends observable at that time have receded while others have prevailed, making necessary sharp revisions in our thinking.

History of the Development of this Manual

An early draft of some of the examination forms used in the present book was prepared in 1919, based on the procedures used in the Boston Psychopathic Hospital and the teachings of Professor Ernest Southard. This draft was successively revised at frequent intervals by group action in the Menninger Clinic. Particularly involved in this were Doctors C. F. Menninger, William Menninger, Robert Knight and later Doctors David Rapaport, Lewis Robbins and Edward Greenwood.

In 1938, I presented our schema before the annual meeting of the American Psychiatric Association as "An Outline for Recording the Dynamic Structure of the Personality" and the same at greater

length at Ohio State University Medical School in Columbus that same year. This schema was used and further developed at the Menninger Clinic. Some subsequent revisions were made in 1946 when the Menninger School of Psychiatry was established in connection with the Winter Veterans Administration Hospital, and the necessity arose for instructing large numbers of young psychiatrists in the procedure of personality study. A more radical revision was undertaken in 1950 by a group of us, including the late Dr. Helen Sargent, then Chief of the Psychological Service at Winter Veterans Administration Hospital, and later on the staff of The Menninger Foundation. We were particularly concerned with the revision of the so-called mental status (or psychological) examination in line with new insights into "ego psychology" and the various new personology theories which were emerging. From a survey of many clinics, hospitals and training programs, we discovered that not only the mental status but the entire process of case study was generally felt to be in need of revision and restructing in the interests of better communication, better teaching and better records. This is what we attempted to do in the *Manual* of 1952.

Since the appearance of the first edition we have had additional help from many colleagues, and have made annual revisions of almost every chapter. So many changes have been made in it that except in purpose and general outline, the present book will seem to be quite dissimilar to the original. There have been ten years of trial use by residents and their instructors. Thus the present text represents an evolutionary product of group thinking. Like all such products, it must be regarded as tentative and transitional, subject to constant further changes consistent with new discoveries and changing concepts in the various departments of science.

The *Manual* assumed a dynamic concept of illness as the expression of personality-environment interaction in the course of which some stresses or exigencies result in adaptive measures which are unilaterally or bilaterally harmful. A more complete statement of our concept of personality and illness will appear in another volume. The present *Manual* is a practical guide to the physician in the collection, organizing and interpreting of the data of psychiatric case study. This we regard as the primary specific skill of the practicing psychiatrist.

Minor Changes

In addition to the major changes in the contents of the *Manual* already discussed, the following minor points might be made. We have omitted material which was in the Appendix of the first edition, including the model commitment law. We no longer regard the law there submitted as a model. The adjunctive therapy modalities listed in the first edition have been considerably supplemented and at the same time simplified in actual practice. The personality types listed in the first edition were highly arbitrary at the time and are no less so at present. It is equally if not more satisfactory in the description of personality to use simple nontechnical adjectives with no implied typological meaning. We have also omitted the sample case studies because we found from experience they tended to be used as models rather than as examples.

The first edition contained a chapter on the re-referral of a patient to the referring physician and a chapter on the writing of psychiatric reports and papers, in which we discussed in particular the importance of accurate communication. The communication of findings of the psychiatrist to referring physicians, judges, relatives and others requires both science and art. It also requires considerable flexibility, depending upon the purposes for which the communication is intended. For these and other reasons we felt that a more comprehensive treatment of the matter was necessary and hope to present this later in a separate volume.

By many good friends in child psychiatry we were urged to include a special section on the case study of children because of the sharp differences in technique required in certain areas. After much discussion we concluded that it was better to emphasize the basic principles of all history-taking and examining without reference to the age or condition of the subject, allowing the examiner to make the necessary changes according to the situation and his special skills and experiences. Similarly we have omitted special sections on the examination of geriatric patients, court cases, personal injury indemnity cases, veterans and others. Suggestions from various child psychiatrists have been interpolated in the text at various points.

For particular purposes, other more specialized outlines will be required. Indeed, various such useful outlines now exist. Clinical

data may be organized conceptually at various levels with more or less observational and inferential material. The outlines by C. P. Oberndorf, Lawrence Kubie, Ian Stevenson, Margaret Fries, Jules Masserman, Frederick Thorne, E. K. Beller, Kenneth Appel and Edward Strecker, Paul Preu, and The Menninger Foundation Psychotherapy Research Project are all examples of this. We commend these to the interested reader.

Acknowledgments

In addition to those mentioned above, acknowledgments are due Mrs. Helvi Boothe and Mrs. Marcia Leader who assisted with the section on history-taking from relatives. In the first edition credit was given to three secretaries: Mrs. Adams, Mrs. Bryan and Mrs. Sellars; of these Mrs. Bryan remains with us and has worked on this edition, as did also Miss Lillabelle Stahl. Acknowledgment is also made to assistance from Miss Vesta Walker, our medical librarian; Mrs. Mary Lee of the Publications Division; and Mr. Nelson Antrim Crawford, professor of scientific writing in the Menninger School of Psychiatry.

Valuable suggestions regarding various parts of the book were received from Doctors H. L. van der Waals, Ishak Ramzy, Herbert Schlesinger, Nathaniel Uhr, John Segerson, Robert Switzer, Keith Bryant, Cotter Hirschberg, Ernest Hirsch, Povl Toussieng, Lois Murphy, Joseph Satten, Harry Levinson and William Menninger.

As the senior author I would like to acknowledge the great help of my associates. Dr. Martin Mayman has been associated with me for over fifteen years and assisted the late Dr. Helen Sargent and me in the original revision of the psychological examination, which in a way formed the nucleus of this book. Dr. Paul W. Pruyser is associate director of the Department of Education; he teaches a substantial part of the case study course in the Menninger School of Psychiatry and is closely affiliated with Doctor Mayman and myself in writing.

K.A.M.

Topeka, January 1962

"IT IS A RARE PRIVILEGE TO WELCOME SUCH A BODY OF MEN INTO OUR MIDST AS I NOW HAVE THE HONOR TO DO.

"OSLER ONCE SAID WHEN ADDRESSING A CLASS WHO WERE JUST ENTERING UPON THE STUDY OF MEDICINE, "THE HARDEST CONVICTION TO GET INTO THE MIND OF A BEGINNER IS THAT THE EDUCATION UPON WHICH HE IS ENGAGED IS NOT A COLLEGE COURSE, NOT A MEDICAL COURSE, BUT A LIFE COURSE, ENDING ONLY WITH DEATH FOR WHICH THE WORK OF A FEW YEARS UNDER TEACHERS IS BUT A PREPARATION.'

"YOUR PRESENCE DEMONSTRATES THAT THIS CONVICTION HAS GOTTEN DEEP AND THOROUGHLY INTO YOUR MINDS, THAT THE STUDY OF MEDICINE IS A LIFE COURSE FOR YOU. TO HAVE THE FELLOWSHIP OF MEN WITH SUCH CONVICTIONS IS A GREAT GRATIFICATION TO US AND WE FEEL HONORED BY YOUR COMPANY. WE WELCOME YOU TO THE STUDY OF PSYCHIATRY."

C. F. Menninger, M.D.

(To a group of physicians enrolled in a postgraduate course in psychiatry at the Menninger Clinic in April 1935.)

CHAPTER I

Meeting the Patient

From time immemorial, certain individuals have been set apart in every human society as possessing power to assist in the process of personal reparation, power to relieve pain, power to forestall death and to promote recovery from injuries. For many centuries these individuals were regarded as not quite human and were believed to possess supernatural powers. With the development of biological science and its acceptance by physicians, these supernatural attributes were replaced—in the doctors' minds at least—by scientific knowledge, a knowledge dependent upon certain techniques of investigation, of observation, correlation, and confirmation. It is in these techniques that the greatest changes in medical practice have occurred, and they in turn are reflected in—and at the same time determined by—the changing concepts of personality through the centuries.

For the service of the physician, the patient is willing to pay money—if he has it. He promises obedience; he does what the physician tells him to do. He accommodates himself to the physician's convenience.

But he gives something more than all this. He surrenders his right to personal privacy. He submits himself to an examination. This was not a part of the procedure of the earliest physicians, or even of those of the Middle Ages. The old chestnut, so familiar a part of the experience of every doctor, in which the patient when asked what is wrong with him replies, "This is what I want you to tell me, *you* are the doctor," is a residual indication of this feeling on the part of the patient that the doctor has a magical, mysterious intuition as to the nature of the patient's disability, sight unseen. Although to some extent doctors are tempted to play this wizard role, scientific medicine repudiates magic powers and insists upon procedures of collecting data.

But however much intelligence and traditional practice may lead a patient to accept the necessity of such collecting of data, his

submission to the routine of examination is always tinctured with feelings of concession. This is apt to be forgotten by the modern physician, trained as he is in the formula, "Examination is necessary to diagnosis; diagnosis must precede treatment." The historical development of the patient-doctor relationship indicates how false this axiom is; the patient comes to be *treated* and everything that is done for him, so far as he is concerned, is treatment, whatever the doctor may call it. In a sense, therefore, treatment always *precedes* diagnosis.

The questioning and examining of a patient is so ingrained a part of the standard procedure of modern medicine and, indeed, the pattern of modern civilized life, that it is no wonder that doctors sometimes fail to appreciate the extraordinary uniqueness of this role. The lowliest general practitioner, in however shabby a little office in the remotest country town, has an authority and a prerogative which few kings have ever had, which the Pope of Rome never had, which the highest judge in the highest court in this land never had. He has an opportunity to obtain an intimate, minute and yet extensive view of another human being. Even the intimate friend is denied this.

From his special coign of vantage, the physician may scrutinize his fellow man's past history and present status in all of its aspects. The physician may ask questions regarding every phase of the patient's life. Nothing is too intimate, nothing is too secret, nothing is too prejudicial. More than that, the doctor may ask the patient to disrobe. He may inspect and palpate and even puncture the patient's body. He may listen to the sounds made by the patient's internal organs; he may pass tubes or instruments into body orifices, or examine the shadows revealed by the X-ray; he may collect from the patient blood, urine, feces, and other body substances for particular examination; he may give the patient adventitious substances and check their specific effects. In examining children, there is the added factor of the authority, power, economic means and determination of the parents. Their "magic," as the child may perceive it, will interact with the physician's "magic" in various ways. Children may see the physician's powers as an extension of those of the parents, as a counterforce to parental control, or as an added parental threat and stronghand.

The great boon of this extraordinary privilege accorded the physician is the opportunity it gives him to formulate a precise description of a particular individual including the illness or injury from which he suffers. The correlation of the two essential techniques of historical or longitudinal survey and cross-sectional survey gives us a three-dimensional view of the human being in relation to his environment.

I have directed your thinking in this direction as a background for a mental attitude which should characterize the approach of *any* physician to *any* patient. It might be summed up as one of respect for the dignity of the suffering human being and of reverence for the mystery of pain and impaired growth. With this, too, goes a respect for the responsibility and authority of the role of the physician.

All that has been said here applies to medical, surgical, obstetrical, dermatological *and* psychiatric patients. The psychiatric patient differs from other patients in several important respects, however, which determine the peculiar qualities of his approach to the psychiatrist and of the psychiatrist's approach to him. Let us consider some of them.

In the first place, the patient who finally decides to seek the help of a psychiatrist does so in the face of an undeniable social stigmatization. Mental trouble is just as prevalent as dental trouble, and there should be no more disgrace attached to going to a psychiatrist than going to a dentist. Yet, compare the situation of an employee who requests time for medical treatment of heart symptoms with that of an employee who requests time for a visit to a psychiatrist! A physical illness is often something to boast about; a mental illness rarely is. Consequently, the pressures internal and external have usually become pretty severe before the patient or his relatives reach the point of taking the step that means, at least to other people, "There is something wrong with his mind." Both the patient and his family—sometimes one more than the other—endeavor as long as possible to deny that the patient is sick, or at least sick in this particular way. It is not surprising, therefore, that before the psychiatric patient gets to the psychiatrist he has often wistfully solicited help from the surgeon, the osteopath, the gynecologist, or the faith healer. These individuals, anxious to meet

the challenge, not infrequently play into the hands of the patient's evasions and do something for him, or to him. It is only the wiser, more skillful ones who help him to overcome his reluctance and his fears and to go straight to the psychiatrist.

This fear of social censure joins hands with another fear which is peculiar to the psychiatric patient. Mental illness is mysterious; in its extreme form, it is horrible. The verdict of the psychiatrist may confirm the unspoken dread: "Insanity" may be just around the corner. This is a burden of fear great enough for anyone. But added to it always are such secondary fears as the fear of exposure, the fear of being laughed at, the fear of being humiliated by the examination, the fear of "being locked up." All patients come to the physician with a certain amount of fear, but the psychiatric patient with most of all.

One effect of this fear is to increase the patient's defensiveness; at the very moment that he is approaching the physician for help he is withdrawing and preparing to conceal that for which he needs help. All human beings—indeed, all animals—approach one another with a certain tentativeness, in which, as Freud has shown, there is a preliminary phase of hostility. In ordinary human contacts this hostility is quickly overcome by the human equivalents of nosing, smelling, licking and pawing. We establish whether the stranger comes as a friend or as a foe. This is much harder for the psychiatric patient to do, not only because of the fears just enumerated, but because his illness has disturbed his machinery for gauging reality and also for establishing interpersonal relationships. It is like a man with a crippled hand upon being introduced to a surgeon whose first impulse might be to shake hands—the very thing that such a patient cannot do. And just as the surgeon would have to find other means than the conventional ones for conveying his friendliness to this patient, so the psychiatrist must learn to depend upon many other means than the conventional ones for establishing rapport with his patients.

The psychiatric patient is not only fearful and hostile, but he is embarrassed. He has no protrusions, no tumors, no points of tenderness, no fever. He has nothing that can be seen. He has only something that he can tell about.

But *can* it be told about? Can it be described? Can it be made

clear to anyone? Will even the psychiatrist understand it? Will he believe it? Will he tolerate it? These are added reflections which appall the psychiatric patient.

Harry Stack Sullivan commented that the beginning student in psychiatry is put to work at the most difficult task, namely, that of getting the history of the psychiatric patient. "Can they imagine what it would be like to undergo the events they have heard about? To be where the informant claims he was? That is, do they have a sense of its being possible really to follow what he says? If they do not they should say they do not understand! When they cannot follow, they should ask questions. It is that simple. This also calls for competence in language—a remarkable sense of the nuances of communication. . . ."

This remarkable passage sums up in a few words two of the most important and most distinctive features in the psychiatric tête-à-tête. To "imagine what it would be like," to try to put oneself in the place of the patient, and see the world as he must, misapprehending things as he does, suffering as he seems to—this is an exercise in projection which the young psychiatrist must learn to do. It is just what he has unlearned in his medical schooling, where one must learn *not* to suffer, even in fantasy, as the patient does, and *not* to see things as the patient does, lest it impair one's objectivity and make the practice of merciful medicine unbearable. On the other hand, in approaching the psychiatric patient in the hopes of understanding him and his afflictions, one must, as Sullivan suggests, try to imagine how it feels.

Sullivan speaks truly too, of special competence in the means of communication, chiefly language, which the psychiatrist must possess, or acquire. This is not only essential in the initial interviews, but for the entire diagnostic process. It is the basis of much of our therapy. For in addition to the fact that the patient has justifiable doubts about the ability of the psychiatrist to understand him, there is the fact that the patient does not understand himself. It is hard enough to describe something that one is clearly aware of; it is still more difficult to describe something which one is not clearly aware of, but is disturbed by, and it is still more difficult to put this in a form which a second party (the psychiatrist) will grasp, and grasp sympathetically.

Sometimes it is also uncertain who the patient is. When parents request an examination for their child, the first step is to define what the problem is, whose problem it is, and whether a psychiatric examination at this particular time is called for. Parents with a child in acute distress may request the examination not to help the child but to provide themselves with legal ammunition in contemplated, or ongoing divorce proceedings. They may request it with the purpose of getting the child pronounced "normal," or their request may cover a wish for obtaining psychiatric help for themselves. They may seek an examination only in order to bolster their authority with the child, for example, to try to stop a teenage daughter from marrying.

Finally, the psychiatric patient differs from most medical and surgical patients in that his illness involves not only his interpersonal relations and his means of communication, but psychological processes the counterparts of which exist also in the physician. The patient's symptoms and behavior often awaken impulses and associations and reactions within us which we have had trouble enough of our own to manage. This tends to upset us, and to disturb our objectivity. It may arouse pity rather than sympathy, anger rather than regret, contempt rather than curiosity, erotic feelings rather than friendliness, anxiety about oneself rather than concern about the patient. The patient's illness forces him, or let us say, permits him, to do things which we do not permit ourselves to do, and sometimes this has the tendency to create envy and resentment. The patient may be provocative; he may be seductive. It is much more difficult for a psychiatrist to maintain his objectivity when exposed to such things as this (as he is with every patient), than for the surgeon to maintain his objectivity in performing an appendectomy.

I recall seeing a surgeon, who was very proud of his manual dexterity, shudder at the prospect of repairing some terribly mangled fingers, and I once saw another colleague overwhelmed with anger by the forcible expulsion of infectious matter into his face. The psychiatrist is constantly subjected to more disturbing and threatening assaults on his personality integrity than these more obvious and dramatic illustrations. And he, too, must control himself.

The psychiatric novice may feel overwhelmed by the complexities and difficulties of psychiatric treatment which requires an approach different from what he has used before. It will require much

trial-and-error experience before he can develop a certain attitude that will enable him to act with spontaneous correctness. Perhaps the following "rules-of-thumb" will help him in his early efforts to learn this approach.

Some Practical Suggestions

In meeting your patient for the first time, take the initiative. It is your move. He has already taken the initiative, or someone has, as evidenced by the fact that he is in your office or hospital. Now it is up to you to carry the ball for a little way. Help him over this critical moment, remembering that all patients are afraid, ashamed, embarrassed, a bit hostile and justifiably distrustful. Put him at ease.

Naturally you will see him alone. His story is private and personal and confidential and embarrassing. You may see him occasionally, earlier or later, with relatives and with nurses, but in really getting acquainted with him he must be your sole object of attention.

Be sure that your patient is as comfortable as he can be. His chair should be more comfortable than yours, not less; he should not have to stare at a window with a light half-blinding him (as might be quite proper in a medical examination where visual inspection is important).

Talk first about the weather, or his recent arrival, or his home town, if you like, or go directly to his headache if that seems best. You will have to sense this in advance. But avoid like the plague such banalities and insults as the initial queries which one so often hears (and uses, in other situations), "What's the matter?" "How are you feeling?" "What's wrong with you?" "What can I do for you?" "I want to take your history." "When was your father born?"

Begin in the most natural way possible by telling the patient who and what you are, if he does not know, and asking him simple, conventional questions. Proceed from the known to the unknown, *i.e.*, from things held in common such as the place, the weather, the circumstances, friends, or current events, to (a) things which the patient alone knows, and only much later to (b) things which you alone know, *i.e.*, explanations, information and advice.

Speak quietly and naturally and in tune with the patient's mood. If he is trying to be cheerful, be the same—but not flippant. If he is depressed, respect that fact. If he is silent, respect his reasons by in-

quiring about them patiently, not reproachfully. Tone of voice and manner are hard to prescribe, but the essential thing is to convey to the patient that you are seriously interested in him, desirous of helping him, prepared to listen attentively and uninterruptedly, and capable of understanding and responding. Actions speak louder than words, but one must use both words and actions. The skilled psychiatrist makes his moves with sufficient smoothness, slowness and steadiness so that the patient's fears recede in favor of his burning impulse to seize the extended hand of help. Sincerity, earnestness and unhurriedness ought to be taken for granted; unfortunately, they are by no means universal.

Let the patient know that you are on his side. While you know it, he does not—at first. Even if he is wrong in what he says, he is telling you how he sees it, and you must see it that way with him before you can get him to see it differently (which will be much later). Such expressions as "I see what you mean." "Naturally." "Well, I don't blame you." "But why did they do that?" act as catalytic agents in an interview. Do not lose your balance, however, by which I mean this: Do not be so bent upon convincing the patient that you are the best friend he has, or ever had, that you put him in the embarrassing position of being afraid to tell you the truth later on for fear of disappointing you. You are a physician, not a nurse, and making him comfortable is for you a means to an end. While you must convince him of your trustworthiness and of your genuine interest, you should not seduce him into thinking you approve of his continuing to do anything he wants to do. Set him an example of objectivity. You want to collect certain facts and look at them to see what they mean; help him to do that with you.

Remember to listen to what he says; listen, too, for what he does not say. After a rapport is established—not before—you can begin asking pointed questions about what has been omitted, but lead up to these gradually. Thus, for example, do not come out with a blunt "Are you suicidal?" Rather, "You must have felt pretty badly about it. . . . And did you remain pretty low-spirited? . . . Clear down, eh? . . . And did you want to give up entirely? . . . How desperate did you get? . . . Did you think of ending it? . . . How were you going to do it?"

At the right time you should explain what you propose to do, for example, in the way of further history, physical examination and

ward prescription. Do not do too much of this explaining. Listening is your main role for a few hours, perhaps many hours, but do not leave the patient hanging. He wants you to listen, but he also wants you to do something about it. Hence in leaving him, make the next step definite—*when, where,* and *what.* You must also account for the interim. What is he to do in the meantime? You are responsible, you know. He is your patient; you have assumed the responsibility. Let him feel this, and help him feel a sense of continuity between the various times of personal contact you make with him.

Children especially are usually quite apprehensive when they are brought for examination, even when they hide behind a front of breezy bravado or sullen anger. They sense their parents' apprehension; they are liable to think of themselves as "bad" and fear they are going to be changed into an unfamiliar, new person. They may expect shots, or frightening procedures. The psychiatrist, aware of such apprehensions, will try to dispel them by his manner and words. If you are tall, avoid towering over the child; sit down. If mother and child anxiously clutch each other, demonstrate that you do not intend to separate them right now. Avoid speaking loudly. Do not stick to verbal communication, but give opportunity for play and movement. Respect the child's need for distance when he is anxious.

Be especially reticent in asking questions about sexual matters until the patient is quite familiar with your purpose and methods, and can accept such questions as part of a thorough and systematic examination of his life and habits. Even then, remember that you are a psychologically-minded physician and not a statistically-minded contributor to the Kinsey Report. You do not have to know all the details.

In regard to taking notes, a great deal of nonsense has been written and spoken. Very few patients object to it *after* the first few minutes. Most patients are impressed favorably by your wish to make a careful record. Some are disturbed by it, however, and you should notice that quickly, act accordingly—and stop! Remember what you can and fill in your forgettings later.

With these general and specific comments regarding the approach to the patient we shall go on to the more detailed instructions regarding the taking of a psychiatric history.

"EVERY FACULTY OF ACTION, AND CONSEQUENTLY EVERY TALENT, IMPLIES AN INSTINCTIVE FORCE AT WORK UNCONSCIOUSLY AND IN IGNORANCE OF THE RULES WHOSE PRINCIPLE IS, HOWEVER, IMPLICIT. THE SOONER A MAN BECOMES EDUCATED, THE SOONER HE LEARNS THAT THERE IS A TECHNIQUE, AN ART, WHICH WILL FURNISH HIM THE MEANS OF ATTAINING THE REGULAR DEVELOPMENT OF HIS NATURAL FACULTIES. IT WOULD BE IMPOSSIBLE FOR WHAT HE ACQUIRES TO INJURE IN ANY WAY HIS ORIGINAL INDIVIDUALITY. THE SUPREME GENIUS IS HE WHO ASSIMILATES AND APPROPRIATES EVERYTHING WITHOUT PREJUDICE TO HIS INNATE CHARACTER. HERE WE ARE CONFRONTED WITH THE DIVERSE RELATIONS BETWEEN CONSCIOUSNESS AND UNCONSCIOUSNESS. THROUGH AN EFFORT OF EXERCISE, OF APPRENTICESHIP, OF PERSISTENT AND CONTINUOUS REFLECTION, THROUGH RESULTS OBTAINED, WHETHER GOOD OR BAD, THROUGH THE MOVEMENTS OF RESISTANCE AND ATTRACTION, THE HUMAN ORGANS AMALGAMATE, COMBINE UNCONSCIOUSLY THE INSTINCTIVE AND ACQUIRED, AND FROM THIS AMALGAM—FROM THIS CHEMISTRY AT ONCE CONSCIOUS AND UNCONSCIOUS—THERE ISSUES AT LAST A HARMONIOUS WHOLE WHICH FILLS THE WORLD WITH WORDS."*

* *Letter from Goethe to von Humboldt, March 17, 1832. Goethe was then eighty-three years old; he died five days later.*

CHAPTER II

The Psychiatric Case History

COLLECTING, ORGANIZING AND RECORDING HISTORICAL DATA

The earliest inception of an illness always antedates the physician's observations of any manifestations of it. The disease process, with the attack and counterattack of the conflicting forces, has been going on for some time before it has reached the point where the pain or insight of the subject, or the distress and the wisdom of his friends, or several of these, lead him to appeal to a physician for help. Thereupon, an intricate and complex relationship immediately develops. The physician may now examine and observe; he can investigate what the disease is doing to the patient, and what the patient is doing with the disease. What has occurred prior to his observation the physician must learn at secondhand. This specific function of collecting retrospective data has come to be regarded as basic in medical practice—the ascertaining, as accurately as possible, what the developmental structure of a personality, especially with respect to the presently disturbing state of being, has been. The doctor can correctly identify and organize the *contemporary* features of the illness only in the light of this history.

The Rationale of Psychiatric History-Taking

Because clinical histories are so important in psychiatric case study, it might be worthwhile to devote a few paragraphs to some reflections on the philosophical basis of history-taking. The emphasis in medical school is apt to be on the collection of information relating to the presence or absence of certain disease states in the patient, *i.e.*, did he ever have this, or did he ever have that, and as for the present condition, when did it first appear? This is pathography rather than biography. The clinical histories made by Hippocrates, while fragmentary, were not the histories of the de-

velopment of some illness but rather records of the development of certain suffering human beings. In this respect modern psychiatry has reverted to the Hippocratic model.

In any history-taking the physician must make a selection among the many details presented by the patient, neglecting some and expanding others. This selection is determined by one's model of illness, by one's subjective interests, by all sorts of criteria, not all of which are scientific or objective. At the time the physician begins to make his collection of data and, therefore, his selections, he does not yet know the totality of the history, but as he proceeds he grasps more and more the direction it is taking.

This philosophy is reflected in our "standard operating procedure" in history-taking. The family history, the developmental and social history of the patient, the occurrence of previous illnesses and the details of the evolution of the present affliction are systematically inquired into, recorded and studied by every competent physician. In some cases, special inquiries are made into occupational, military and marital events and adjustments.

The influence of the changing concepts of disease in medicine has been to expand the original scope of medical history-taking and to shift some of its emphases. Medical case histories tend more and more to borrow from the procedure of psychiatric history-taking. But there remain many important differences between the approach of the internist or general practitioner and the approach of the psychiatrist to history-taking which are among the first lessons the resident must learn, coming to psychiatry, as he usually does, with training in standard medical history-taking procedures.

Comparison of Medical and Psychiatric Case Histories

The psychiatric case history differs from the medical case history in a number of ways. A first difference is in respect to the multiplicity of *sources* from which the data are obtained. In general medical practice, the patient, unless unconscious, or of very tender years, is the chief source of information, and by all means the most reliable source. No one knows so well as the patient *where* and *how* it hurts. But in psychiatry this may or may not be so. The patient is often the least reliable informant; sometimes he is simultaneously

the most reliable and the least reliable. In all instances, therefore, the psychiatric history depends upon information derived from a number of sources—members of the family, employers, employees, teachers, friends, police officers, and various professional colleagues. All of these sources of information add something, and yet are certain to be incorrect in some respects, uninformed in some respects, biased or dishonest or disingenuous in some respects. Someone must integrate the total supply of information and correlate the details in order to get an approximation of how the patient was and how he appeared to other individuals at a time now past. This information, in turn, must be correlated with the patient's own story.

The psychiatric case history also differs from the medical case history, further, in the techniques used to acquire the data, both from the patient and from others. A surgeon called to see a man with a sharp pain in his abdomen will have no difficulty in getting responses to his questions; indeed, the more prompt and businesslike he is in ascertaining the essential facts, the better the distressed patient is apt to feel about it. Even in less urgent situations, the physician can usually obtain the history of the illness and the preceding circumstances through a series of direct questions submitted in a more or less arbitrary sequence. In taking a psychiatric history, however, it is rarely possible to come quickly to the point; frequently the patient does not have the slightest idea what the point is, any more than does the physician. The patient may not even know what hurts or "matters," and those who know him may not be eager or even willing to tell what they know or think about him.

Instead, the psychiatrist is in the position of having to ask the patient about many things which will certainly seem to him irrelevant if not impertinent. Again, the patient may be impelled to do far more than answer questions; he may talk quite freely and even volubly for long periods of time without giving the physician much enlightenment. And it always takes not less than several hours to get a history in a psychiatric case, as contrasted with the much shorter time employed by the internist, and with the few minutes which may suffice in some surgical cases.

In general medical practice and in surgery, both the doctor and the patient are likely to feel that the procedure of history-taking *precedes* treatment, and that it is done for the purpose of deciding

what the best treatment should be. In psychiatry, however, the very process of history-taking may have a therapeutic effect, marking the beginning of treatment. Not realizing this, some psychiatric patients anticipate the direct-questioning approach traditional in doctor-patient relationships and become dissatisfied, impatient and uncooperative with any different approach.

Still another way in which the psychiatric history differs from the traditional medical history concerns the *attitude of the patient* toward his illness. In general medical practice, the patient usually takes the initiative in seeking treatment. But in the case of the psychiatric patient, his relatives or friends may attempt to impose treatment upon him, so to speak. Lacking insight into the nature or severity of his illness, or without any predominant wish for relief, his attitude may range from extreme negativism or belligerence to extreme indifference, apathy and mutism. Even the most cooperative patient, who seeks a psychiatrist of his own accord, is often highly ambivalent both toward psychiatry in general or toward the psychiatrist as a person. The apprehensiveness, hesitation, blocking, forgetfulness, glibness, intellectualizing and circumstantiality which he may show in the interview situation reflect not only the fear which is frequently inherent in psychiatric illnesses, but also the unconscious wish to cling to and preserve an illness by way of making the best of a bad bargain. These varying attitudes considerably influence the techniques necessary for the task of history-taking.

Children's difficulties frequently reflect the presence of environmental problems, especially in the family. The child is far more dependent on his family than most adult patients; moreover, his symptoms are more clearly distortions in his growth and development. The psychiatrist must, therefore, deal with the family dynamics and in some way size up the parents; their own emotional turmoil is likely to be reflected in the child's behavior.

Finally, the most obvious difference between the medical and psychiatric history is in content, *the data* selected as relevant to the illness. The traditional medical history in contemporary practice (or terms), includes investigation of the ancestry, childhood, past life, past illnesses, and more recent experiences of the patient. But in such a history the emphasis is usually placed upon definite events. In a psychiatric history it is not sufficient to obtain a record of such

events, no matter how complete a list or how accurately dated. Far more important to the psychiatrist than the actual events are the psychological reactions of the patient to those events, and the subsequent modifications in his attitudes and behavior which result from them. For example, in eliciting information, let us say, about the death of a patient's father, the general practitioner would be interested in the father's age at the time of his death, the cause of death and perhaps the duration of the final illness. A psychiatrist, on the other hand, would be much more interested in the patient's age at the time his father died and how the patient felt and reacted on that occasion, how long the patient grieved, and how the patient's work and attitudes were affected. The psychiatrist would be interested in how the patient feels now about that death which occurred so long ago. The area of the psychiatrist's interest can be illustrated in many other ways, but perhaps for the moment this example will suffice.

Furthermore, the *patterns of behavior* which have come to characterize a patient, as exemplified in his interpersonal relationships, do not usually concern the medical historian but they very definitely concern the psychiatric historian. This is dramatically illustrated by the studies of Dunbar* and others regarding repeated accidents. Consider a patient who is admitted to the hospital for the seventh time with a traumatic fracture. From the standpoint of the medical historian, the dates and circumstances and the nature of the fractures previously sustained are important with reference to such questions as the resulting disability, the question of possible calcium deficiency, and so on. The psychiatrist, however, immediately tries to learn how the circumstances in which these fractures were sustained are comparable, since, from his standpoint, the illness is not the fractured bone, or even some conceivable bone weakness that favors a fracture, but the curious propensity of the patient to get into situations in which torsion of an extremity and injury of a limb are so consistently the outcome.

The discoveries of psychoanalysis have very considerably influenced the content of the psychiatric history by pointing up the

* Dunbar, H. F.: *Synopsis of Psychosomatic Diagnosis and Treatment.* St. Louis, Mosby, 1948.

importance of events, particularly childhood experiences, hitherto considered negligible. We shall say something of these shortly in connection with the detailed program of investigation. Psychoanalysis has also influenced psychiatric history-taking by recognizing the *unconscious* motives of the patient in the illness and in coming to the doctor, and the extent and effect of his fear and other covert emotions regarding treatment. Fear of the physician may be related to a fear of bad tidings, but it often depends upon the very guilt feelings and anticipation of failure which have led the patient to seek psychiatric help. Besides fear, the patient may bring feelings of humiliation and damaged pride over having to admit to himself his inability to deal adequately with his problems. The special fears or resentments of the hospitalized patient, particularly if his hospitalization had been initiated by others, are—or should be—always in mind as tending to distort the historical record.

These are some of the more significant ways in which a psychiatric case history differs from a medical case history. Enumerating them in this way does not do justice to the considerable change in attitude and method required of the psychiatric student in moving from general medicine into the psychiatric field.

The beginner in psychiatry is often overwhelmed by the vast amount of historical data which accumulates—so much history, or rather so many histories, so many different histories, different histories even from the same individual! The doctor is suddenly made aware that no individual is correctly observed by his friends, and of the even more astonishing fact that no individual correctly observes himself, least of all when he is well, nor correctly remembers more than a bare outline of his life experiences. He has usually forgotten some of the most painful and important events. It is nevertheless necessary to get an approximation of the succession of events which both determine and explain the patient's relationships with the environment, relationships which have now gone awry as expressed by the illness. This awryness has never come about suddenly, "out of a clear sky" as the saying has it, but represents a continuation phase of the life process. We must attempt to describe this process, both in its inconspicuous pre-morbid phases and in its more dramatic period of pain and protest.

Procedures in the Obtaining of Clinical History Material

In practice two general sorts of procedure are followed. The psychiatrist in private practice will listen to his patient or his patient's relatives or both together or both separately. From these interviews he will obtain data from which he will endeavor to reconstruct a probable course of events and an approximate outline of the progressive development of the maladjustment. This he will set down as a part of his clinical record of the patient. As he examines and treats the patient further, and confers additionally with the friends or relatives, he will add to this history and also record his examinational findings and the progress of the case in treatment. This assumes essentially no assistance from psychiatric social workers, psychologists, associated physicians or other colleagues.

In the clinic or hospital, on the other hand, where a multidisciplinary approach is possible, there can be a division of labor and responsibility. Facts regarding the development and the unsatisfactory adjustment as seen by various members of the environment—the relatives, friends, employers, employees and others—can be collected by the physician, the psychologist or the social worker, or all of these. Sometimes the nurse is in the best position to do this. But psychiatric social workers have particularly developed these skills, and in many clinics and hospitals they assume this responsibility routinely. Whoever obtains the history of the illness from others than the patient will inevitably obtain information of two kinds—the historical facts relating to the development of the illness and the attitudes which have crystallized in various parts of the environment toward the patient.

From however many sources the information is obtained, it must be correlated with the account given by the patient. This is sometimes difficult to achieve with very young patients and in such cases the biases of parents and the discrepant views of each parent regarding the child need to be checked against data obtained from other sources: teacher, family physician, social agency, or other relatives. As we have stated, no history is accurate and no history is complete, but we must strive toward both accuracy and completeness which requires a careful scrutiny of discrepancies in varying accounts.

History-Taking from the Patient

We described in Chapter I how the initial contact between a psychiatrist and his patient develops after many preliminary events have occurred. Sometimes these leave a haze of uncertainty and ambiguity surrounding the interview. This will usually be dispelled by the quiet pursuance of the purposes of the contact—granted certain skill, perseverance and resourcefulness. The physician should assume that every patient wishes to communicate something, even when he refuses to speak. The physician avowedly wishes to receive these communications and to understand them. When a contact has been established, the physician's offer to help accepted, and the patient able to speak, the history-taking process will have begun.

The patient is probably trying to say: "This is the way I am. It is not the way I want to be. It is not the way I was." The historian will note this, but listen attentively to hear data pertaining to "how I *was*" and "how I came to be the way I am." In other words, the doctor will be listening for material relating more or less reliably to past events as well as for material relating to the immediate present.

From one standpoint all of these data can be considered historical information; from another standpoint all of them can be considered the raw data of the present examination. The interviews in which the physician attempts to learn the life history of the patient and the life history of the illness *as the patient expresses them* will also provide the psychiatrist (or the psychologist) with an opportunity to observe the psychological functioning of the patient. This point has to be emphasized for beginning psychiatrists. The function of history-taking and the function of psychological examining overlap. But there will have to be additional efforts made to complete the history-taking and additional steps to complete the psychological examination.

There is a temptation for young psychiatrists to bolster their own insecurity in the delicate situation of the initial interview by proceeding too quickly and methodically to a census-type of interrogation: "Where were you born? At what age did your father die?" In reaction to this tendency some of my colleagues have insisted that *no* systematic anamnestic queries be put to the patient. This, in my opinion, is to throw out the baby with the bath. There is a time

for such questions, and there is a time when such questions should be scrupulously avoided. (See, for example, Gill.) Much of the following material has been abstracted or quoted from the excellent article on psychiatric history-taking by Ian Stevenson and Robert A. Matthews.

The patient usually begins by talking about his symptoms and it is well to let him talk himself out, even though several interviews may be thus occupied. While he is describing his symptoms, the doctor will be thinking of and looking for the circumstances surrounding the onset of symptoms, and the circumstances in which they recur or are intensified. Is there a pattern of their recurrence? Is there a common type of reaction, such as depression, resentment or anxiety, associated with them? What does the patient do when he has symptoms? Are his relations with others or his performance at work interfered with only then? If so, is there some gain as well as loss to the patient in the illness? Has he ever been entirely free of symptoms for a long period and if so, what was going on in his life then? Some of this information cannot be obtained or sought directly from the patient; but the idea of obtaining it should be in the mind of the physician as he listens to the patient and gathers his material

After the patient has described his symptoms and discussed the tangential topics which have arisen, he can be led into a further discussion of his present life situation. Again, by exploiting his digressions and parenthetical remarks, the patient's associations may be drawn to similar events that occurred in early life. If the patient speaks of feeling under pressure at work, he may be asked, "Did you ever feel that way while you were still in school?" In this way, we obtain a picture of the recurrent patterns of his behavior and the repetitive problems of his life.

By the time the current life situation has been reviewed, the patient has usually become accustomed to talking about himself. The physician may turn the patient's attention to the subject of his early and developmental background, and social and family history, by making some such remark as "Now tell me something about your very early life, what you remember of school, friends and family when you were a child." The items which the patient chooses to talk about first are noteworthy—but the items he postpones men-

tioning may be even more important. If he resists talking about his early life, he can often be led indirectly to giving this information by inquiry into his family history. After the tangents leading out of questions about the family have been explored, the patient's resistance to talking about his own life and feelings will often have been dissolved.

A more rounded picture of the patient is obtained if we try to see him as a whole at different periods of his life rather than in different activities of his life. It may be useful to have in mind the whole span of a person's school life or his work record; but it is even more helpful to have a picture of the whole person as an infant, a boy, a young married adult, and so on. For each period of life we want to have some information about what can be called the emotional climate in which the patient lived. What were the dominant forces in the shaping of his personality? What were the values, the goals, the attitudes of the people who surrounded him? To what stresses were they exposed? How much of these stresses were obviously of their own making? How did they and the patient react to such stresses? To what extent has the patient resisted or discarded, either unconsciously or with deliberate intent, the attitudes which he learned as a child?

The aim of exploring attitudes and feelings is to identify those which are most important to the patient. Reactions to stress are determined more by the personality of the subject than by the nature of the stress. Consequently we must search for the significance to the patients of events, regardless of their significance to ourselves. To do this the physician must be alert to signs of emotional charges, and to changes in emotional charge, associated with topics about which the patient is talking. Patients rarely say, "This is important to me but it makes me sad to talk about it," or, "It bothers me to talk about my mother."

Some General Principles

Stevenson and Matthews enunciated several principles as the basis for techniques of psychiatric history-taking: flexibility of the physician; the need for taking time; the importance of detail; complete acceptance of the patient; minimal activity by the phy-

sician during an interview, and avoidance of frontal attack and leading questions.

Flexibility in the physician. Especially in early interviews, the physician should adapt himself to the needs of the patient and attend to those problems for which the patient seeks immediate assurance; afterward, he can lead the patient to recognize other needs and problems. If the patient goes off on a tangent, it it better usually to let him follow it up than to bring him back to his original topic.

The doctor should try to be flexible in his emotional response to the patient. If the patient is anxious, the doctor should be firmly reassuring; if he is depressed, the doctor should be optimistic without being cheerfully hearty; if he is angry or suspicious, the doctor should be friendly but not ingratiating or defensive. If the patient seems extremely anxious or confused, the doctor may attempt to alleviate these feelings by taking more time than usual with inquiry about neutral material (*e.g.*, physical symptoms, or the nature of his work), or by lingering on a topic that appears to interest him (*e.g.*, a hobby).

The need for taking time. "Short cuts in psychiatric history-taking belong to the experienced who do not often use them." Too often the doctor feels that he should propose a diagnosis after the first examination, but rarely does the patient insist upon it. An adequate period of time set aside for history-taking not only insures thoroughness, it also allows the physician to observe fluctuations of symptoms and relate these changes to changes in the life situation and emotional state of the patient. Time is also needed to enable the physician to phrase his questions and comments appropriately.

The importance of detail. The physician should cultivate an interest in everything about the patient. Detail often appears tedious and time-consuming, but circumstantiality may be the best or only means available to the patient for communicating the significance of a particular event to him.

Complete acceptance of the patient. The patient will reveal his inner feelings only if he feels that he is accepted unconditionally by the physician. The patient responds not only to the questions asked but to the manner of asking. Consequently the physician must learn to control the expression of his attitudes. He should look upon all

behavior as having a meaning and serving a purpose for the patient; the doctor will be unsuccessful if he considers only the effect of the patient's behavior upon those around him or upon society. The doctor's acceptance of the patient does not necessarily imply approval of his attitudes or behavior, but it does imply a complete acceptance of the patient as a person notwithstanding them. Without this prevailing tolerance the physician's feelings are likely to be transmitted—often insensibly—to the patient and will deter him from further revelation of his feelings. The physician should be moral but not a moralist.

Part of tact is the ability to describe a person as he sees himself. Questions should be phrased with respect for the patient's concept of himself. When a patient ventilates much hostility toward a boss, the physician may be tempted to say, "Do you always have trouble with bosses?" The patient, however, is apt to talk more freely if asked, "Have you found other bosses as troublesome as this one has been to you?" Instead of saying, "Have you been on relief often?" the physician may say, "Have you had much trouble finding work?"

Similarly, we must, at least at first, accept the patient's own evaluation of his experiences. If he tells us people are reading his mind, instead of asking, "Are you sure they are reading your mind?" or, "What makes you think they are reading your mind?" the physician might word his question more tactfully, "Why should they read your mind?" and, "Who are they?"

Minimal activity by the physician. A rule of thumb is that as long as the patient is talking, the physician should listen only. Interruptions by the physician can be cut by about 90 per cent if he asks himself before interrupting what information he hopes to obtain or what other purpose will be served by interposing a question or remark. In general, questions and interruptions should be restricted to the following occasions:

1. Opening the interview or introducing a new topic of information. For example, "How have you been since I saw you last?" or, "I thought perhaps you could tell me something more about your early life."

2. Eliciting essential material not given spontaneously by the patient, such as ages and dates. Such questions should usually be reserved until the patient's flow of words has temporarily ceased.

3. Reducing irrelevant material and circumstantiality. Usually it is wiser to note the material produced during apparent irrelevancies than to cut it off. If we accuse our patients of being irrelevant we are really confessing that we have failed to understand the significance to the patient of what he is saying. We can often learn much from apparent irrelevancies by listening carefully. Sometimes the patient is filling in time until he can bring himself to expose his inner anxieties. Sometimes he is feeling out the sensitivity and understanding of the doctor on small issues before presenting him with a major problem. Sometimes the patient is justifying his conduct against inner (and assumed external) accusations and criticisms. Sometimes the irrelevancy is the patient's unconscious or guarded manner of presenting his real problem.

Often we can better understand irrelevancies if we ask ourselves, "To what unasked question could all of this talk be the answer?" We may then find that a woman who talks at great length about her operations is answering as if someone had said, "You have suffered a great deal in life, haven't you? Tell me all about your suffering." The patient has a need to show how much she has suffered. Much of what patients tell us consists of answers to such unspoken questions. Where material is obviously repetitive or wastefully circumstantial, however, it is permissible to say, "I think perhaps it would be more helpful to spend the remainder of our time talking about some of your other problems. Tell me about such and such."

4. Reassuring the patient of his acceptance by the physician, and of the "understandability" of the patient's reactions.

5. Focussing on relevant material. If the patient, while talking about something which is apparently irrelevant, touches upon an important relationship, or an area of conflict, or if he shows evidence of emotional change, the physician should seek to channel the discussion in that area, either at the time or later. This should be done with minimal activity. Often if the doctor merely looks more attentive and interested, the patient will move into the area spontaneously. Sometimes a word or phrase such as "And?" or "And then?" is sufficient to keep the patient talking. Sometimes a word or phrase of the patient may be fed back to him as an inviting question. The patient may say, "I always seem to feel worse on Saturdays"

and the physician may then merely say, "On Saturdays?" and the patient will usually go on, "Yes, I have a lot to do on Saturdays as my mother-in-law comes over to see the children on Saturdays."

It is not always appropriate to focus upon an area of importance as soon as it is noted by the physician, especially if the more subtle invitations to further discussion are not accepted. The physician should merely record the apparent importance of a topic and look for an opening later. Frequently, material of great importance may be touched upon in the first interview but cannot be explored until later.

The physician may gently coax, but should never force, the patient to discuss topics which he does not wish to talk about. Reticence is usually a symptom of anxiety. Later, when the patient has overcome some of his anxieties and has greater confidence in the physician's acceptance of him, he may spontaneously open up the charged topic.

If such a topic is broached and the patient appears about to become seriously disturbed, the physician should usually deflect the conversation into a neutral area. On the other hand, if the patient wants to go on in spite of crying or other emotional disturbances, he should be allowed to do so. Occasionally, a patient may say after a long pause, that there is something that troubles him but he feels ashamed or too embarrassed to mention it. If the doctor replies "Possibly you would prefer to wait until another time, but I am sure it cannot be that bad," the patient may feel sufficiently reassured to discuss a subject previously taboo.

If the physician undertakes to restrict his interruptions to such occasions he will, admittedly, find himself struggling against strong temptations to interject comments and interpretations. Many patients, and some physicians, try to find a single "cause" to which all of the patient's difficulties can be attributed. This belief may lead the physician to offer rash interpretations of dynamic origins. He will be less liable to do so if he remembers that the personality of the patient is always more important than traumatic events in the development of illness. He should also remember that traumatic events are rarely isolated but are usually composed of continued pressures or a series of similar inimical events or attitudes. Finally, he should remember that the insights and correlations developed

by the patient himself are the only ones of lasting value to him; those imposed by the physician may be accepted intellectually but have little real meaning for the patient. Premature interpretations may deflect the patient's stream of thought from the topics at hand and impede the taking of a good history; worse, they may irritate, confuse or frighten him.

In taking a psychiatric history no outline should be used too rigidly. Keep in mind the one goal of coming to know the patient—past and present—as a person. If he is encouraged to talk freely and is guided gently, the patient will eventually deliver all the important material, which can later be restructured for the record. Adhering to an outline of questions sometimes encourages the habit of conventional questions and unrevealing answers. The formal outline of material offered here is meant to be used as a guide, for it is useful to have in mind certain definite areas of investigation which must be covered.

History-Taking from Relatives

Many of the principles and techniques just described are applicable not only to interviews with the patient but to interviews with relatives. They, too, have been disturbed by the events of the patient's illness and by the steps taken toward obtaining relief. They, too, have had their wounds, discomfitures and bewilderments. The relatives are often greatly helped by the very process of communicating with the history-taker, even though its direct object and subject is the patient.

In a continuing search for ways to gain the most accurate knowledge about the whole situation, it would be ideal if we could interview all of those with whom he has had relationships. This of course is never possible. The referring physician will usually be the first contact and informant. He will see the psychiatrist. Either the psychiatrist or the social worker, or both, will then see the parents, the spouse, the siblings or children. Teachers, employer or employees, friends, and clergy will be additional sources of important information, as people who have either known the patient all his life, or observed him in special periods.

Such collections of historical data, including various impressions

or interpretations of the patient's behavior reported by observers, represent at the same time an examination of the environment and a history of the patient's life and illness as they have affected the environment. These data have traditionally been described as a *social history*, although actually they are also a kind of examination of the environment and its disorders as well as an account of the patient's development. A social history tells both how the patient is affected by and how he affects his cultural milieu.

The core of inquiry is the family constellation. This is not only the immediate interpersonal environment of the patient, but comprises also the individuals to whom the patient himself is "environment". How he appears to his relatives is sometimes quite different from how he appears to himself, or how he appears initially to the examiner. The relatives' concept of the problem, their point of view, their emotional reactions—all these may be quite different from those of the patient. He may or may not be aware of the reactions of others to him, or he may perceive them falsely.

History-taking from people other than the patient differs from history-taking from the patient because of its difference in focus. The interviewer must focus primarily not on the person or persons interviewed but, *through them*, on the patient. The patient is the person around whom the family constellation, other people and circumstances of the patient's social functioning are elaborated. In this context the social history examines the patient's interpersonal and social relationships as viewed by those people who have been or are a part of his past and current environment. Their views of the mutual adjustments between them and the patient, of the events which have occurred in his development at various age periods, of their reactions as well as his to these events leading up to the present examination, may be different in many respects from the patient's views. While there are types of information which only the patient can give, there are also types of information about the patient which only others can give, or can give better.

Interviewing relatives serves a second purpose, namely, that of observing the relatives themselves at firsthand. This gives valuable clues in assessing their attitudes and social behavior, particularly the constructive and destructive aspects of the roles they assume toward the patient. An assessment of the strengths and weaknesses of the

patient's past and present in the immediate family situation has a bearing on the total psychiatric diagnostic formulation leading to treatment planning.

In the very process of securing historical material from relatives, a relationship is established which both assists in obtaining as reliable as possible an account of material, and provides an opportunity to make some evaluation of their personalities as they may have affected the patient.

Interviewing the relatives of a patient to supplement his own account of his history has come to be one of the functions of the social worker in psychiatric clinics and hospitals. The social worker shares with other professions the perspective which views man and his environmental situation, particularly other people, as mutually interacting forces. The very fact that the social worker is not a physician, although possessed of some medical skills, is often an advantage with some relatives, and with some nonrelatives who can be good informants. But every psychiatrist should have experience in history-taking from relatives.

There is still another function in the history-taking interview with the relatives. This has to do with informing, instructing or reassuring them in ways that must in a broad sense be thought of as therapeutic. The history-taking can be a part of the larger process of helping them with problems connected with their disturbed relationship to the patient. Tentative discharge planning can begin even in these initial interviews. This will not be discussed here because we are now concentrating upon history-taking.

Recording the Definitive Clinical History

We have yet to discuss the *recording* of the assembled historical data. The relatives will have given to the psychiatrist or to the social worker certain information. The psychiatrist will be obtaining certain information from the patient. The various clinical histories will be filed in the case record, but their essential content must be reconciled and abstracted or summarized for the case summary to be discussed later, as the definitive historical account of the patient's life and illness. For this abstraction the psychiatrist is responsible. He is also responsible for the selection from all of the historical data,

some of them contradictory, which seem to be most credible, and of sufficient importance in relation to the present illness picture to be brought forward as clarifying data. This task is even more difficult than the original collecting.

Clinical histories are customarily divided into sections on the basis of chronological development. It is fairly standard in psychiatry to use five main areas, *viz:*

A. GENERAL STATEMENT OF THE PROBLEM
B. PRESENT ILLNESS
C. FAMILY HISTORY
D. DEVELOPMENTAL HISTORY
E. ADULT ADJUSTMENT PATTERNS

The GENERAL STATEMENT OF THE PROBLEM is a statement of the circumstances and reasons given for the patient's having come to the examiner. The patient's problem as he sees it, as the family sees it, as his referring physician sees it, and as it appears to the examiner may be four different things, all requiring declaration.

The account of the PRESENT ILLNESS should *always begin* with an adverbial clause of time related to the admission date or examination date. Examples: "Three months ago, while the patient was preparing breakfast . . ." "On New Year's Day, two weeks prior to admission, while the patient was asleep . . ." It should then continue in detail, chronologically up to the present moment, including the events or discussions or reflections which led the patient to consult a physician or enter the hospital.

There are many ways of acquiring the data relative to the present illness; this has already been hinted at in the previous chapter dealing with the approach to the patient and will be dealt with further as we go along. The examiner must bear constantly in mind the necessity to describe the events as they actually occurred, but there are always two sides to the occurrences—the way they look and feel to the patient and the way they look and feel to the outsider. These two points of view meet from time to time in connection with events in reality which are incontrovertible. Thus everyone might agree, for example, that the patient's father died on Christmas Day. But immediately the two accounts might diverge.

The patient may describe a feeling of overwhelming grief, followed by a sensation of the world going to pieces in a way that filled him with terror, and led to his leaving the house in search of help. The family, on the other hand, may describe incomprehensible shouting, gesticulating and threatening behavior in the course of which the patient dashed recklessly into the street. When the accounts diverge as much as this, one can possibly cite both versions as I have done here. But sometimes the differences are more subtle and the examiner will find it difficult to know what actually occurred. He should, therefore, be careful in citing the authority for the statements that he records. If he has some doubt about their credibility he may express it with the reasons for his doubts.

The account of the present illness should always lead up to the present moment, *i.e.*, the case study itself, including the events or discussions or reflections which led the patient to consult a physician, or enter the hospital and the events subsequent to that, if any have occurred.

The examiner will bear in mind that a little later when he is called upon to make a summary of the case it will be necessary to greatly reduce the length of the accounts of the present illness. In the original account, no relevant detail should be omitted.

Having recorded the present illness, it is conventional to proceed more systematically beginning as far back as there is relevant information—hereditary, familial, congenital, infantile and so forth.

FAMILY HISTORY: In the traditional "medical history," hereditary and familial disorders are considered most important. The occurrence of such familial disorders as diabetes, gout, cancer, hemophilia, hypertension, convulsions, allergic manifestations, obesity, etc., as well as definite mental disturbances among family members, should be noted if found. But in a psychiatric history we are more interested in the patient's reactions to the afflictions of other members of the family; how the illnesses, deaths or chronic disabilities of other members affected the relationships within the family, particularly the relationship between the ill person and the patient. The death of a parent may be interpreted by a young child as desertion or rejection; illness of the mother may affect the amount of affection which she is able to bestow on her children, and chronic

illness in other siblings may induce feelings of jealousy, rejection, guilt, or inferiority in the siblings who remain well.

The family history section is usually the best place to describe the general and peculiar cultural, sociological and familial conditions characterizing the milieu into which the patient was born. Such facts, for example, as that the family was a member of the Mexican colony in a mid-western, largely Protestant community, or that the patient was reared on the campus of the University of California where the father was a professor, belong not to the childhood history, but to the family history. To be born the youngest child of six siblings, or posthumously, or in poverty or in wealth, or one of twins can significantly affect the subsequent adjustments of the child, regardless of any innate qualities. Many of these factors are not necessarily traumatic but have important influences on the development of the personality.

This section should include an account of the attitudes and characteristics of the family and its members because from family attitudes the child acquires much of his own attitudes toward life: work, play, sex, aggression, religion, education, success, independence, money, even illness. Some families encourage free expression and creativity, others rigidly follow only established and accepted patterns of behavior, still others are iconoclastic, antisocial, or disorganized. Some families are patriarchies, some matriarchies, others partnerships in which all share together. In some families a child's efforts to become independent are encouraged, in others inhibited; love may be freely given or cruelly withheld; sons may be favored over daughters or vice versa.

DEVELOPMENTAL HISTORY: This refers to the period from birth to adult life. This is conventionally subdivided as indicated in the topics to follow.

Much information about the earliest years, so important for understanding personality development, cannot be obtained. In addition to the amnesia blanketing these early years of infancy and childhood, the psychiatrist frequently encounters the patient's indifference and resistance to direct discussion of this period of life, which is, of course, a manifestation of the depth and extent of his repression of these memories (and perhaps also that of his relatives).

The more skillful the psychiatrist and the more familiar he is with child psychology, the more adept he will be in eliciting this information by tracing clues found under "Present Illness" and "Family History."

The birth history may yield clues indicating congenital or hereditary defects or deviations in development; and from the psychological standpoint, it may throw light upon early "sets" in parental and family attitudes. Specifically, the pertinent information would cover such items as the age and health of the mother during pregnancy, medical data concerning delivery, the mother's attitude toward her pregnancy, and the parents' feelings regarding the sex of the child.

The infancy history is a valuable source of information for evaluating early relationships with the parents (particularly the mother). The following list of areas for investigation may be helpful:

a. Early predisposition.
b. The course of mental, physical and motor development.
c. Sleeping patterns, with particular references to disturbances.
d. Nursing and weaning experiences (age and method) and any special feeding difficulties.
e. Toilet training, age at which initiated and completed, methods used, and any special problems such as enuresis, soiling, etc.
f. Signs of "nervousness" such as excessive crying, fears, tics, stuttering.
g. Major illnesses, accidents and surgical procedures, age, reactions, complications.

Such information not only tells us about the patient's early physical development, but supplies information regarding the manner in which the mother (particularly) met the child's needs and his response to her ministrations. Premature weaning or toilet training may, for example, reflect rejecting or overly strict attitudes toward the child's instinctual expression. From such information one may gain important inferences about the prevalent emotional climate in which the child was reared.

The early childhood history should supply data pertinent to the further development of the adjustment patterns begun in infancy. The child's increased motility and expanding social relationships will introduce many new factors. The following points may be investigated:

a. Family living conditions, work and play patterns in the home, sleeping arrangements, etc.

b. Relationship with father and mother; attitude of parents in regard to discipline, favoritism or rejection, over-protectiveness, etc.

c. Relationships with siblings and other children. The birth of younger siblings is usually more or less traumatic but subsequently the siblings may be the most important love objects. The timing of such events is apt to be highly significant (e.g., a child may be abruptly weaned or toilet trained because of the expected arrival of a baby or changes in sleeping arrangements may be made).

d. Attitudes toward sexual differences.

e. Expressions of masculine or feminine identification.

f. Special traumatic events and unusual conditioning experiences.

The school history and period of later childhood. This part of the history pertains to the mental development, the early identifications, the nature of relationships to contemporaries and adults outside the home, the general patterning and the emerging personality, and the early indications of emancipation from the family. These trends are more specifically defined in the following terms:

a. Physical development; health.

b. Age when schooling began; progress and reactions in the grades and high school, attitudes toward transitions, e.g., grade school to high school, favorite or disliked subjects.

c. Relationships with teachers and other pupils.

d. Nature and extent of extracurricular activities (*e.g.*, interest in hobbies, sports, scouts, etc.).

e. Truancies and other behavior problems such as lying, stealing, etc.

f. "Nervousness," excessive shyness, sleep and eating disturbances, etc.

g. Attitude of parents toward school progress.

h. Earliest sexual instruction or experiences.

i. Outstanding events in the environment (*e.g.*, move of family to new community, death of parent, etc.).

j. Illness and injuries and reactions thereto.

The adolescent period history will continue with consideration of:

a. Physical development and health: acceleration or retardation, illness, operations, embarrassing blemishes, etc.

b. Sexual development, menstruation, masturbation, emissions, hetero- or homo-sexual experiments and the patient's reactions thereto.

c. Interpersonal relationships within the family and outside, including idealized and inspiring figures and specially hated or ambivalently held figures.

d. Social and sociological factors such as rejection, memberships, popularity, poverty, religion.

e. Educational continuance, interest, ability and achievement; age and grade when left school and reasons.

f. Sublimatory opportunities and patterns, work and play habits, hobbies, interests, conscientiousness, etc.

g. Relations to property, money, pets, art, nature and other nonhuman objects.

h. Goals, fantasies, aspirations and ideals.

i. Manifestations of emancipation from home and parents.

j. Neurotic symptoms and signs such as enuresis, temper tantrums, sleep walking, nail biting, truancy, stuttering, eating disturbances, outstanding fears, or tendency toward anti-social behavior such as lying, stealing, cruelty to other children, etc.

k. Important experiences.

l. Vivid memories and dreams from this period.

ADULT ADJUSTMENT PATTERNS may be considered under the following heads:

Work patterns. Goals, chronological sequence of jobs held, wages and success; geographic locations; attitudes toward employers, fellow workers, organized labor, own employees, work done; special skills, fatigability, punctuality, absenteeism.

Play and cultural activities. Quality and quantity; satisfactions derived, hobbies developed, talents.

Social adjustments in general (interpersonal relationships). Friends (number, constancy, sex preference); membership in organizations, lodges, etc.; civic activities; feelings of social, educational, cultural or religious inadequacy; political interests; religious interests and activities; general traits (*e.g.*, frankness, generosity, attitude toward money, orderliness, friendliness); eccentricities.

Sexual development up to and including spouse and children. This need not be spelled out in detail here; the main trends and satisfactions (or dissatisfactions) are usually sufficient.

Medical history (adult life), including previous hospitalizations for episodes of mental illness. Some psychiatrists like to record a medical or health history separately, sometimes referred to as a system review, in the belief that the taking of this part of the history serves to "warm up" the patient to the task of further examination of more personal aspects of his life. Most patients are familiar with this type of inquiry and young psychiatrists, because of their

previous medical orientation, often find themselves more comfortable to begin their examination with this "routine" inquiry.

Military history (or other specialization) should include outstanding experiences, type of duty, length of time in combat, severity of combat experience, reactions thereto and to other events of military life, length of service, and date of discharge.

Climacterium and aging history. In many patients, male and female, the approach of middle life with the cessation of menstruation, diminution of sexual potency, lessened physical activity, the departure of children from the home and the approach of retirement constitute a source of great apprehensiveness, depression, uncertainty and other reactions. These are sometimes related to reality factors, sometimes to narcissistic injuries and sometimes to fleeting encounters with the spectral image of death. Many psychiatric patients fall into an age group where these attitudes and reactions are important for the understanding of the total picture of his disorganization.

Recording of Especially Confidential Material

In the course of taking a history the psychiatrist becomes the repository of highly confidential information. The more he gains his patient's confidence, the more intimate may be the revelations. Similarly, in talking with the relatives he is entrusted with intimate data relating to the patient, and perhaps various family secrets and skeletons.

The patient and his relatives are (usually) laymen. They are not always familiar with the fact that the physician's scientific training impels him to make a complete and detailed record of all the data he obtains. They may have a general idea that records are kept, and perhaps if they thought it through they would realize that such records cannot be accurate if they are censored, so to speak, or materially altered. On the other hand, they would be dismayed indeed if they felt that some of the information they supply would be made available to persons other than the physician to whom they gave it.

This is an especially perplexing problem today because of the increasing authority of the hospital. Time was when clinical records were the doctor's property, but today it is almost universal that they are either *exclusively* the hospital's property or *also* the hospital's

property. Whether or not the doctor keeps records for himself, the hospital must have its own records.*

Of course the clinical records *are* available to certain authorized persons. The patient's permission is always necessary as a part of this authorization. This permission is often granted by the patient on the tacit and unsound assumption that any "damaging" material has been deleted.

There is yet another horn to this dilemma. It is true that the physician has a loyalty to his patient and a responsibility for treating the professional relationship with respect and honor. But the doctor also has other responsibilities. He has a responsibility to society, to the hospital, to the rest of the medical profession, and to science. No patient has a right to exploit the confidential relationship offered by the physician to make the physician a *particeps criminis.* The physician cannot condone moral and legal irresponsibility on the part of the patient and to do so may be actually harmful to the patient. For example, a patient comes to a VA hospital with certain psychiatric symptoms and in the course of his history he confesses that he has been receiving compensation for self-inflicted gunshot wounds, which he had claimed were received in combat. The psychiatrist who receives this information has no right to withhold from the clinical record the fact that the patient has been defrauding the government, even though this confession was made in confidence. Another instance that recently came to my knowledge was one in which a patient was accepted in a VA hospital for treatment for which he was completely ineligible. Because certain individuals were sympathetic and felt that he needed the hospitalization (and considered that the information concerning his ineligibility was given to them in confidence and could not be betrayed), they joined in concealing this information from the Registrar over a period of nearly two years. In effect, this was conspiracy to defraud the government and did irreparable harm to the patient even though those in charge of him really felt that they were doing the best thing. If a patient tells a doctor in confidence that he has brought a time bomb into the hospital and hidden it under the bed of one of the other patients, it is a strange doctor

* In the Veterans Administration, the clinical records belong not to the hospital but to the Veterans Administration.

indeed who would feel that this professional confidence should not be violated.

The doctor is thus between two fires, or rather between four or five fires. In the interests of scientific honesty and scientific method, he is required to make a detailed recording of data obtained from a patient who is under the impression that he is giving this information in full confidence. The doctor cannot take the absurd position of warning the patient not to give him his confidence when most of the doctor's efforts are being expended in precisely the opposite direction. On the other hand, he has responsibilities to society, to his colleagues, and to the hospital which may involve transmitting some information which the patient assumes to be a professional secret. In the vast majority of instances these records will be consulted only by colleagues, besides the original recorder. A patient may return after some years or may write in for information about certain facts or suggestions. The patient may consult a colleague in another city and wish a memorandum about his case forwarded.

Professional men have an established regard for the confidentiality of such material and little hazard to the patient can occur from such exchange of information. It would only be done, of course, when approved by the patient. But in rare instances, a court may subpoena clinical records which the doctor would prefer not to release.

For these reasons, the doctor should have certain principles clearly in mind and the following suggestions will help him. He should remember first of all that he has this multiple responsibility. In the long run, the honest fulfillment of responsibility to all parties will be of the greatest benefit to each one of them.

In the second place, no information about a patient is released without authorization by the patient or his legally designated guardian. Moreover, no information is provided except that which is essential to the purposes for which authorization is secured. In practice, this means that a psychiatrist answers specific questions about the patient. It means that other persons are not hurt or involved, that confidential information in the record from sources other than the patient is not disclosed, and misleading impressions derived from reading case summaries or test reports which are written in technical language are kept to a minimum. It means

that a clinical folder in its entirety is never made available to lawyers, insurance investigators, or any other interested parties—even though the patient may have "authorized" the release of this information.

Psychiatrists should see to it that material in a record is couched in such terms that innocent parties—and the patient—will not suffer if it has to be revealed. A great many details are recorded by inexperienced psychiatrists which do not contribute to the scientific understanding of the case or to the value of the clinical history. Proper names, for example, should rarely be given in full. Sexual derelictions and irregularities need not be described in detail. To say of a female patient that she had a number of unsatisfactory, casual love affairs is fully as significant and far less damaging than to say that she had sexual intercourse five times in Trenton, New Jersey with a plumber named Joe Brown. It is just as significant to say that a patient developed acute abdominal pain requiring a salpingectomy, as to spell out that she became infected with gonorrhea and suffered from leukorrhea for many weeks until it involved her pelvic organs.

A few words should be said about clinical histories prepared on cases in a teaching hospital. Not quite so much caution is required here because if the patient knows that this is a teaching hospital, he realizes it is customary to share information and opinions with consultants and associates pledged to professional silence. Even here, however, the examiner should have it very much on his conscience that he is responsible for the extent of dissemination of the information. Ninety-nine per cent of the time there is no serious problem involved, but carelessness in regard to the remaining one per cent, when a patient's reputation may be at stake, can cause a great deal of trouble. I remember, for example, the doctor who permitted the case history of a patient to be typed by a stenographer who was engaged to be married to the patient. From this clinical history she learned that the patient had had syphilis for which he had been successfully treated, but concerning which he had said nothing to her.

Sometimes it is inescapable that a considerable amount of very confidential material must be recorded if the case record is to be at all adequate or useful. Usually such cases are not used for teaching purposes and the especially confidential data are some-

times recorded on separate sheets of paper, often of a different color, separately filed with a cross-file reference. They are sometimes given a designation that is clearly understood by all concerned and access to them is sharply restricted.

Variations in Technique and Types of History-Taking

The schema outlined in the preceding section for the clinical history in psychiatric cases is of a standard pattern. Only after the young psychiatrist has mastered it thoroughly should major deviations or modifications be utilized. The time will come and circumstances will arise when various modifications can and should be made. While we regard it as pure charlatanry to claim to have "examined" a patient competently in an hour or two, some patients can be appraised grossly in a shorter time than is required for a full history-taking and psychological examination. Experience and facility with psychiatric concepts will enable a well-trained psychiatrist to select salient areas of investigation and to give a reasonably accurate skeleton picture, both of the patient's development and of his present illness. It is quite impossible to diagram or even to describe the way in which this is done. It depends upon a combination of intuition, flexibility, quick and accurate skill in observation and in exploiting hints caught from the patient's reaction to the interview situation, and long familiarity with characteristic psychological patterns and trends. Some individuals are much more skillful at it than others, but even the most skillful and most experienced never forget that it is at best a compromise, an incomplete investigation.

Another type of history-taking tends in just the opposite direction. This is the so-called associative anamnesis suggested by Felix Deutsch* in 1939 (based on Weizsaecker's method). It consists essentially in refraining from leading questions except to develop in a continuing way various statements, ideas, complaints and comments spontaneously offered by the patient. This is carried to its logical extreme up to a certain point (for a therapeutic purpose) in psychoanalytic treatment. As Deutsch taught it, it involved constant pressure on the part of the examiner toward the tying-up

* The Associative Anamnesis. *Psa. Quart.* 8:354-381, 1939.

of present symptoms with past events. The technique of using this pressure for history-taking rather than primarily for treatment purposes requires considerable practice. It is a useful teaching device, but it is not a good method for obtaining a systematic history, despite the fact that psychiatric residents frequently fall into the habit of using it with a confused notion that they are combining diagnostic studies and treatment (without actually understanding either one!).

Ives Hendrick of the Harvard Medical School believes that all psychiatric residents had excellent training in the "good, old-fashioned standard type of history-taking" until World War II. Then personnel shortages caused neglect of good records, since when "documenting significant 'external' facts about the patient" is no longer routine. "The junior members of our teaching staff are all of a generation in which the fundamentals of history-taking and case organization were not taught or learned, and their ability to transmit to their students techniques they have not themselves acquired is necessarily limited." (Personal communication.)

It cannot be overemphasized that history-taking is as much an art as a science, and that the technique must be adapted to the patient. For example, as Norman Reider has reminded us, some patients, especially intelligent, well-read ones, resent any evidence of formal history-taking. It puts them at ease if the doctor can go along with them in their own program of history-giving with a manifest degree of flexibility and tolerance. On the other hand, there are some anxious, tense individuals who are definitely relieved if the interviews are conducted in a very compulsive, systematic way. It seems to give them the feeling that they are in adequate, controlled hands where they may feel quite safe. Such adjustments of the technique to the patient are implicit if not explicit in the foregoing descriptions.

The staff of the C. F. Menninger Memorial Hospital has developed a systematic list of psychiatric-history topics which has proven useful to both experienced and inexperienced psychiatrists. It can serve the purposes of on-the-spot recording, check list and memory aid and may also help the interviewer to gear his technique to the needs of the patient. (See Chart 1, Clinical History Data Sheet, pages 41-44.)

THE MENNINGER CLINIC
Psychiatry and Neurology

Clinical History
Data Sheet

Name_____
Age_____ File No._____
Dates_____
Examiner_____

FAMILY BACKGROUND

Socio-cultural characteristics

Ages and characteristics of family members

Patient's relations to family members

Other significant persons

Emotional milieu

Family attitudes toward

- work
- play
- sex
- aggression
- illness
- religion
- education
- ambition
- money
- independence
- the patient

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CHART 1

CHILDHOOD

Birth

Infancy

- Nursing, weaning
- Toilet training
- Nervous predisposition
- Sleep patterns; nightmares
- Illnesses

Early Childhood

- Relations with parents
- Relations with siblings
- Living arrangements
- Development, health
- Outstanding events
- Earliest memories

Grade School period

- School adjustment
- Extra curricular activities
- Illnesses
- Symptomatic behavior
- Fantasies
- Recurrent dreams
- Outstanding events

ADOLESCENCE

- Puberty, menarche
- Physical development
- Education achievement
- Health
- Neurotic symptoms
- Hobbies, special interests
- Economics
- Religion

ADOLESCENCE

Hetero-homosexual trends

Sexual experiences

Object-relations

Peer relations

Idealized and hated figures

Aspirations and ideals

Emancipation efforts

Fantasies and dreams

Outstanding events

ADULT ADJUSTMENT PATTERNS

Vocational goals

Job relationships

Medical history

Military history

Social adjustment

- Friends
- Memberships
- Activities
- Hobbies
- Interests

Family adjustment

- Spouse
- Children

Sexual adjustment

- Sexual and marital history

ADULT ADJUSTMENT PATTERNS

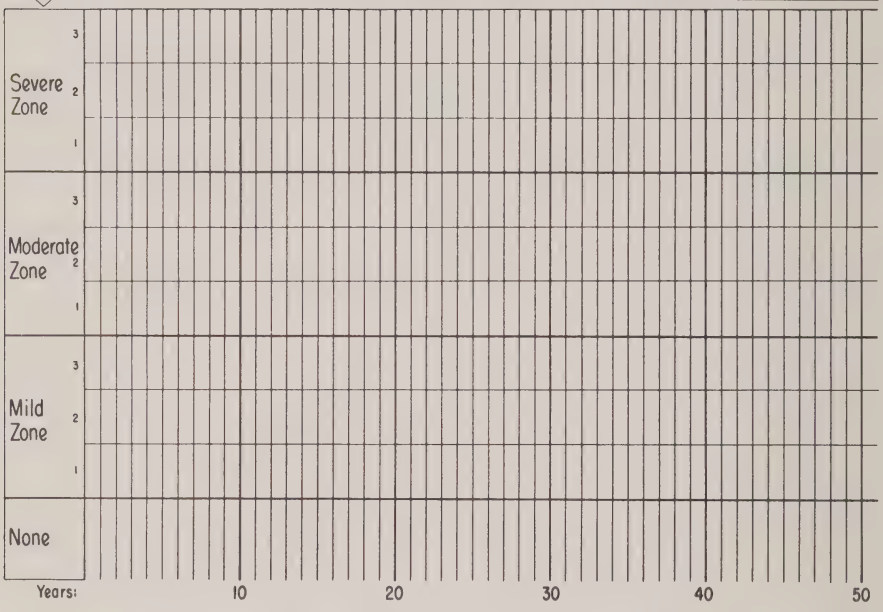
Outstanding events

Present illness

LIFE COURSE GRAPH

Degree of illness

Patient's Name _____
Date Period _____



Circumstances

_____ M.D.

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"... RECORD YOUR OBSERVATIONS! HAVE A SYSTEM OF YOUR OWN. HERE IS THE IMPORTANT THING. MAKE A CAREFUL HISTORY OF YOUR CASES. BEGIN TO DO IT NOW. BE BRIEF BUT FAITHFUL. . . . I KEEP A SMALL SHEET OF PAPYRUS FOR EACH CASE, AND WHEN I RETURN FROM THE VISIT I MAKE A NOTE." *Hippocrates.*

This is the version formulated by Wilder Penfield in his novel, The Torch *(Little, Brown & Company, 1960), page 278.*

CHAPTER III

Examinational Data

A. The Physical Examination

THE PHYSICAL EXAMINATION of his patient is one of the psychiatrist's responsibilities and privileges. It is an integral, essential part of the total personality study. It may contribute invaluably both to diagnosis and to treatment. But under certain circumstances and with certain techniques, it may obstruct both.

In making physical examination of *any* patient, the responsible physician will have acquired almost as second nature a pervading awareness of the transactional nature of the process. This is a clumsy way of reiterating what was emphasized in the first chapter of this *Manual:* namely, that access to the person is granted by a patient to a physician on the basis of a centuries-old understanding. This understanding is in the nature of a contract. On the one hand, the patient surrenders his personal privacy, his modesty, his conventional form of personal adornment, and even his personal comfort in order to facilitate the collecting of data by one qualified *and* authorized to obtain it. The patient puts himself at an enormous disadvantage, as social and personal advantages are ordinarily considered, in order to enable the physician to make careful, accurate observations. These data are obtained according to a well-established systematic formula of inspection, palpation, percussion and auscultation (accompanied by interrogation, and special tests such as the Romberg, knee-jerk, Kernig, etc.).

Until less than fifty years ago these data were obtained under many difficulties. There were few mediating and facilitating instruments (stethoscopes, thermometers, ophthalmoscopes, etc.), and it was not customary for the patient to completely undress. A device of ancient China, that of pointing to areas on a mannequin corresponding to areas of the patient's body where pain was felt, was but little improved upon in Occidental countries until recently. Obstetrical deliveries, it will be recalled, were long managed entirely beneath draperies.

Today everything has been conceded by the patient on the predication of the competence, the integrity, the dignity, and the scientific objectivity of the physician. It is as if the centuries-old contract had been enlarged to include an understanding something like this: "Though it expose me to the danger of embarrassment, humiliation, the unintended sexual arousal of the physician, or of his contempt or horror, I will conceal nothing by any voluntary means, in the faith that the physician can and will control his personal reactions and be thus assisted by me in his effort to penetrate the concealments of nature."

Such a general understanding is now so widespread in civilized countries that it is almost universally taken for granted. Indeed, it is perhaps too much taken for granted. The young physician is reminded too infrequently of the full implications of the contract.

It should not be forgotten at any time by any physician that his privileges and prerogatives imply a sense in him of responsibility, dignity and restraint. There are factors in the private practice of medicine which tend to insure this, but any sensitive observer who has visited public hospitals, public clinics, and even military and industrial medical facilities must have been disturbed at times to observe the unnecessary roughness, inconsiderateness, and humiliating exposure to which patients are subjected. I mention this here not as a diatribe against careless colleagues, but as a warning of special danger which all physicians must guard against, *especially in the examination of psychiatric patients.*

Physical Examination of the Psychiatric Patient

This is the more important for young psychiatrists to remember because for the psychiatric patient—or, let us say, for *many* psychiatric patients—the physical examination has a far different meaning from that ascribed to it by the average medical or surgical patient. However much discomfited the latter may be by the strangeness, unpleasantness, or abruptness of the examination, he is supported in his ordeal by the desire for relief from pain. The mental pain is less than the physical pain. His relatively unimpaired intelligence and appreciation of reality enable him to understand that the doctor's conscious motives, at least, are good, and that the object of the present discomfort occasioned by the physician is the relief of a greater discomfort.

The psychiatric patient, on the other hand, frequently does not have this solace. As a rule, he is not suffering from physical pain. He may not consider himself to be sick at all. He often sees very little point in these physical manipulations and maneuvers. For him the physical examination is apt to seem an unnecessary, unwarranted, and undesired intrusion into his personal privacy—at best a nuisance and an embarrassment; at worst, an outrage and a torture.

Furthermore, the psychiatric patient does not always bring to the occasion that same degree of realistic understanding or trusting confidence that the medical patient does. For the former the physical examination may be worse than meddlesome and meaningless; it may have a sinister and threatening meaning, colored by delusional distortions. It may mean to him the search for the evidence of sin, or the collection of data to prove constitutional inferiority. It may mean a cold-blooded sexual assault. Or it may mean an attempt to stimulate sexual excitement and assaultiveness in the patient himself.

To make matters more difficult, this sinister interpretation of the examination may not be entirely delusional; there may be a morsel of truth in it. Some unworthy purposes, consciously or unconsciously, may indeed lie back of the physician's routine, standardized investigations. Consciously or unconsciously, some physicians *are* sometimes actuated not a little by curiosity, by contempt, by sadism, and by sexual excitement. In the healthy, conscientious and well-trained physician these elements—often normally present in student days—will have been successfully repressed. But sometimes the pathological hypersensitiveness and morbid "misinterpretations" of the patient tend to revive them, to drag them, as it were, into partial consciousness. This disturbs the idealistic young physician, and his inner disturbance is in turn felt by the patient, so that a vicious cycle is set up.

The physical examination of the psychiatric patient is not only a diagnostic procedure, but may constitute one of the most important steps in the therapy. Sometimes it is indeed the very keystone of the therapeutic relationship. It serves to identify the physician in his professional capacity, and to establish, by means of a now familiar and conventional procedure, a confidence in the examiner

as a doctor. (A nurse or social worker, even a "friend" might take a history or make pertinent inquiries about the illness; *only* a *doctor* examines.) It disproves the common error that psychiatrists are only "talking doctors," not real, honest-to-goodness "touching doctors."

The "laying on of hands" has a deep and powerful significance to the patient. It is most effective if the frankly erotic element in it remains largely unconscious. Psychoanalysts, whose task it is to lay bare as much of the unconscious as possible, usually prefer to spare their patients the stimulation of the prematurely heightened transference effect of a physical examination. Personally I doubt if it causes as many difficulties as does its omission or its delegation to others. It may be that we psychoanalysts rationalize the fact that some of us do not like to do physical examinations, or do not feel competent to do them properly, and discard or delegate a valuable medical prerogative.

The thoroughness of the physical examination pleases the hypochondriacal and "psychosomatic" patient particularly, and even the psychiatric patient with a few somatic complaints can begin to have faith in the doctor who is thorough. And, of course, the examination *should* be thorough, and (with the exceptions to be noted) it should be complete—never cursory. It should include those alert observations of reaction to each examinational procedure and to the examination as a whole which experienced and perceptive clinicians have learned to be so significant. Hence even when a physical examination may not *seem* to be necessary, so far as diagnosis is concerned, it should rarely be omitted by the psychiatrist any more than by the internist, if for no other reasons than these, and as a basis for subsequent assertions by the physician that physical pathology is absent.

Timing of the Physical Examination

From all of this it can be seen that I regard the making of a physical examination on a psychiatric patient as a procedure of especial importance and delicacy. It must be done with the full awareness of the potentialities and the dangers just cited. It must be done only after the patient has acquired some greater than aver-

age confidence in the examiner, and only after the examiner has taken greater than average pains to explain and justify what he is about to do. Proper timing is most important.

The surgical patient can scarcely wait until the surgeon has examined his burning wound or his tense abdomen; the psychiatric patient often dreads the hour when the physician will begin the examination. It sometimes becomes a difficult question to decide how long the physical examination of a psychiatric patient can be deferred with safety. In general, while the physical examination should not be made immediately, it should not be deferred too long. Pathological physical processes may be going on which determine or complicate the pathological mental processes.

But sometimes a patient who is recalcitrant or combative on Monday will be found to be compliant and cooperative on Tuesday, and the doctor must be prepared to take advantage of the change in mood. The most valuable allies a doctor has in examining some resistive or negativistic patients are those members of the nursing and aide staff in whom the patient has developed some confidence. Patients will frequently attach themselves to one in particular; it may even be a kitchen helper or a janitor. But in the presence of this ally the doctor can often proceed with the physical examination without difficulty.

It is unfortunately sometimes necessary to make a partial physical examination on a very resistive patient, even at the risk of having it interpreted as an assault. Under such circumstances it is sometimes useful to administer a sedative some hours in advance of the examination. This is strikingly true of certain confused, elderly patients who are very resistive to physical examination, but who become relaxed and even drowsy under a small dose of chloral hydrate. As always the physician will make such an examination only in the presence of, or with the assistance of a nurse.

In any case, making a physical examination of a psychiatric patient justifies even more than in the case of a patient with a medical illness the use of a technique as gentle, as considerate and as businesslike and impersonal as possible, with a clear emphasis on the physician's purposes. Some standard procedures such as rectal or vaginal examinations will be avoided in patients likely to be frightened or aroused by them.

In the physical examination of psychiatric patients it is particularly important to remember the sensitiveness of the patient, the abnormal sensitiveness if you like, at all times. It might seem unnecessary to urge caution in regard to disparaging comments or facial expressions were it not for the fact that these so often occur almost without the doctor's knowledge of his own error. The average physician, even the young psychiatrist, is often totally unaware of the intense feelings of mortification which some women have about unusually large or small breasts. Birthmarks which interest the doctor chiefly as strange pathological structures are sometimes the seat of painful body-image preoccupation on the part of the patient. A hemorrhoidal tag, a hypospadias or even a uniocular strabismus may be to the patient a source of great humiliation, and special attention to it is painful in the highest degree.

On the other hand, assuming that a patient's confidence in the physician has been well established, it is sometimes extremely useful to ask certain questions in a matter of fact way regarding the patient's attitude toward this or that feature of his anatomy—particularly abnormal features. David Levy* first used this device systematically in the case of children, with whom it is particularly valuable. He proposed a "psychiatric physical" examination, the essence of which was that the physician asks questions during or at the close of the physical examination specifically related to the patient's body. Anatomic variations, scars, injuries, height, weight, body growth, sexual organs, etc., are all inquired about pointedly, although in a casual manner. "Tell me, what have you noticed about your hair? Is it different from other people's?" At the end of a series of such questions the patient is asked "What part of your body would you like changed if you could change it?" The examination is terminated by such reassurances as the physician can give, minimizing exaggerated differences, correcting misinformation and generally endeavoring to reduce any apprehensiveness that may have been aroused.

The information thus derived from the comments of the patient supplies data regarding the body image and other psychological data of a type which cannot be so well obtained at any other time.

* A Method of Integrating Physical and Psychiatric Examination. *Amer. J. Psychiat.* 9:121-194, 1929.

They contribute to the physician's knowledge of body tensions, anxiety manifestations, and especially the body image (Schilder*) or somatic "self-concept." When a patient removes his clothing, he is likely to remove some of his defenses and pretenses with it. Affectations and even normal façades are more difficult to maintain when one is in the nude, and on an examining table!

It is almost universally standard procedure today to make physical examinations on psychiatric patients only in the presence of a nurse. This is not only reassuring to the patient, it is discreetly protective for the physician. Some physicians utilize the nurse as a clinical clerk and dictate some of the physical findings as they are made. This works very well with some patients and very badly with others. The suspicious patient will attempt to read meaning into all of the data dictated; with hypochondriacal and paranoid patients it is undesirable. The safest thing is for the physician to make his own recording (silently, and in writing) of all the data he observes, permitting the nurse to record those data which she obtains for him, such as the patient's height, weight and pulse rate.

Institutions differ somewhat in the forms and symbols used in recording the physical examination data. The forms used by the Menninger Clinic are illustrated as Chart 2, pages 53-54.

B. The Neurological Examination

The neurological examination is normally a part of the physical examination and should be performed with precision and completeness within the limits of the patient's cooperation. Special attention is directed toward functions where symptoms appear; thus the motor examination receives special emphasis where symptoms of weakness of a part or parts exists, etc. Immediate and complete recording of findings is imperative.

In those cases in which an extended neurological examination of a psychiatric patient is necessary cooperation can usually be obtained by simple instructions or illustration. There are exceptions to this: some very resistive patients in whom neurological disorder is suspected have to be restrained for the necessary investigation

* Schilder, Paul F.: *The Image and Appearance of the Human Body.* New York, International Universities, 1950.

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TOPEKA, KANSAS

PHYSICAL EXAMINATION

CODE
Examined:
Normal ✓
Abnormal X
Not Examined O

Name Date Age Place

General Appearance
- Development
- Nourishment
- Stigmata
- Body Type
- Fat and hair distribution
- Skin, Hair and Nails
- Peripheral Circulation

Lymph Nodes

Head
- Skull
- Eyes
- Nose
- Mouth
- Teeth
- Throat
- Ears

Neck and Chest
- Thyroid
- Carotids
- Thorax
- Lungs: Inspection; Percussion; Auscultation
- Heart: Size; Rhythm; Force; Apex; Sounds
- Breasts

Abdomen
- Contour
- Masses
- Tenderness
- Rigidity
- Organs
- Scars

MC-11-1-50

CHART 2

Genitalia and Rectum

Scars

Malformation

Plevic Examination

Rectal Examination

Bones, Joints and Spine

Posture

Mobility

Deformities

Musculature

Tonus

Strength

Tremors, fibrillation

Spasm

Trigger areas

Measurements	Weight	Height	Temp. range	Pulse range	Resp. range	B.P. range
						Standing
						Sitting
						Lying

SUMMARY OF POSITIVE FINDINGS

DIAGNOSTIC IMPRESSION

RECOMMENDATIONS

COMMENTS ON EXAMINATION

Examiner:_____M.D.

of optic discs, Babinski, etc. But patients who are more or less aware of the purposes and difficulties of the examination easily accept peremptory orders such as "walk," "sit down," "shut your eyes," "touch your knee," etc. But patients may also easily become confused, frightened, angry—or all three—when subjected to a series of abrupt orders of this type. I have seen exhibitions which would have been ludicrous had they not been so pathetic, in which an increasingly frustrated physician shouted louder and louder while the patient became more and more negativistic in regard to the most elementary test performances.

The neurological examination can and should be done in conjunction with the general physical examination but the data recorded on separate forms. The form used at the Menninger Clinic, the Topeka State Hospital, and the Topeka Veterans Administration Hospital is illustrated as Chart 3 on pages 57-59. Chart 4 (page 60), which is a part of this examination, refers to the special procedures described in the next section.

C. Laboratory, X-ray, and Other Special Examinations

The clinical laboratory examination of specimens of blood, urine, spinal fluid and other body substances is well established as a part of modern medical practice. Psychiatric practice is no exception. Every psychiatric patient should have a routine blood study, a chest X-ray, and periodical urinalyses. In addition, many patients will require spinal fluid examinations, gastric analyses, electroencephalograms, electrocardiograms, etc. The significance of the data obtained from these examinations and the indications for special laboratory procedures are implicit in the general discipline of medicine, and their application does not differ in psychiatric patients.

The collection of the samples from psychiatric patients is, however, somewhat different from the procedure in general medical practice. It is something which should not be left to the routine activities of the nurse or technician. It is the responsibility of the psychiatrist to make sure that his patient understands *what* is to be done, *why* it is to be done, *how* it is to be done, and *when*. It must constantly be borne in mind that the psychiatric patient is in a frame

of mind to misinterpret things. What for the average medical patient is merely the collecting of a specimen of blood may be to the psychiatric patient an attempt to bleed him to death. What the surgical patient will correctly understand as the pricking of his ear for blood may seem to the psychiatric patient a stab with a poisoned arrow. It should never be assumed that psychiatric patients, just because they are articulate adults, take these procedures for granted and understand immediately just what the physician is doing. On the other hand, neither should it be assumed that psychiatric patients are idiots, incapable of having things rationally explained to them. The tone of voice and the manner used in such explanations is more important than the content. And the tendency to make too big a to-do about it is just as bad as the tendency to consider it unnecessary to mention. A psychiatrist who is closely in tune with his patient will scarcely need these instructions, and a psychiatrist who is not in tune with his patient probably will not profit much from them. However, I have seen so many patients, especially children and psychiatric cases, unnecessarily traumatized by inconsiderate neglect of these elementary principles that I feel obliged to put them in writing.

The same is true of such special procedures as X-ray, electroencephalography, dental examination and others. These things are so familiar to *us* and so free from alarming elements that we must constantly remind ourselves that we are privileged by experience and training. I have seen even very sophisticated, intelligent, *non-psychiatric* patients develop tachycardia and sweating during the course of a simple fluoroscopy of the chest. As psychiatrists, we know about the power of unknown fear and fear of the unknown, but we often act as if we had forgotten.

A final word ought to be said about some procedures which are definitely uncomfortable and even painful, such as the barium enema and the lumbar puncture. The patient should not be told that these are painless. Every effort should be made to keep them as painless as possible, but we all know that there is some pain attached to them, and their very obscurity increases the terror which they inspire in some patients. Knowing this, it is the more our duty to reassure the patient, not with untruths, but with calm explanations and such simple expedients as the pressure of a hand and the presence of a cheerful nurse.

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NEUROLOGICAL EXAMINATION

CODE
Examined:
Normal √
Abnormal X
Not Examined: O

Name Age Date Place

Cerebrum
Orientation
Cooperation
Handedness
Speech

Cranial Nerves	Right	Left
I Perceives Odors		
Identifies Odors		
II Fields (Confrontation)		
Acuity		
Fundi		
III-IV-VI		
Extra-Ocular Movements		
Convergence		
Nystagmus		
Ptosis		
En- or ex- ophthalmus		
Pupils		
Size		
Shape		
Equality		
Reaction to Light		
Reaction to Accommodation		
Reaction to Pain		
Consensual		
V Sensory		
Cotton		
Pin Prick		
Corneal Reflex		
Motor		
Masseters		
Lateral Motion of Jaw		
Jaw deviation on retraction		
Reflex		
Jaw jerk		
VII Forehead		
Eyes		
Mouth		
Masking		
Taste		
Reflexes		
VIII Air Conduction Acuity		
Bone Conduction Acuity		
Lateralization of Bone Conduction		
Caloric Test		

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CHART 3

	Right	Left
IX and X		
Sensation of Palate		
Movement of Palate		
Gag Reflex		
Phonation		
Swallowing		
XI Sternocleidomastoids		
Trapezius		
XII Protrusion		
Tremor		
Atrophy		
Fibrillations		
Speed of movement		
Motor		
Strength		
Upper Extremities		
Lower Extremities		
Tonus		
Upper Extremities		
Lower Extremities		
Coordination		
Finger to Nose		
Heel to Knee		
Rapid Alternating Movement		
Fibrillations		
Atrophy		
Involuntary Movements		
Sensory		
Pin Prick		
Cotton		
Warm		
Cold		
Vibration		
Localization		
Position Sense		
Fingers		
Toes		
Stereognosis		
Figure Writing		
Palms		
Legs		
Two Point Discrimination		
Deep Pain Sense		
Muscle Tenderness		
Nerve Trunks		

Reflexes (0 = absent, + = present but diminished, ++ = Normal, +++ = hyperactive, ++++ = transient clonus, +++++ = permanent clonus)

	R	L		R	L
Biceps			Upper Abdominal		
Triceps					
Radial			Lower Abdominal		
Finger			Cremasteric		
			Knee		
			Ankle		
Abnormal Reflexes			Plantar		

Gait and Station

Static ataxia (Romberg)
Gait
Associated Movements
Hopping
Walking Tandem

Signs of Meningeal Irritation

Stiff Neck
Straight leg raising

Skull

Circumference
Signs of trauma
Exostoses
Contour
Auscultation
Percussion

Spine

paravertebral muscle spasm
kyphosis
scoliosis
lordosis
spina bifida

Autonomic

Vesical sphincter
Rectal sphincter
Perspiration
Other

Additional Observations

Special Examinations

Visual Fields

Cerebrospinal Fluid

X-Rays

Electroencephalogram

Other

Summary of History and Examination Findings

Diagnostic Impression

Recommendations

Comments on Examination

Examiner_____M.D.

CHART 4

D. The Psychological Examination

The physical examination of a patient follows a procedure long established by precedent and practice. In various ways we endeavor to ascertain which body structures are healthy and normal, and which are altered from the normal in some way that we can see or feel or hear or even smell. We proceed in an orderly way and record our findings systematically, classified according to systems or areas of the body.

In general terms, we can do the same thing for the psychological structures and processes. This vast difference exists, however. We cannot see or hear or smell psychological "organs"; we can only observe and elicit responses and infer certain things from these observations. We examine processes rather than cell masses. A psychological examination, therefore, tends to resemble the analysis of electrocardiograms more than it does the palpation of protuberances.

We use the term "psychological examination" to refer to what has traditionally been called the "mental examination" or "report of mental status." For many centuries physicians have made and recorded examinations of the psychological or mental status of patients, but for a long time these were not formalized; they were not systematic; they were not thorough. To say of a patient that he was stuporous and unresponsive or that he was raving with delirium does describe something about the psychological functioning, but it describes it very superficially. Such incomplete psychological estimates could serve a useful purpose only in those patients whose physical symptoms were more serious from a life and death standpoint.

Psychiatrists have always attempted to make some kind of systematic psychological surveys, but have generally been handicapped by the vague, incomplete state of theory and concepts of personality. They had no organizing frame of reference for studying a patient's many interrelated psychological processes. Furthermore, until Freud's discoveries, we lacked tools for ascertaining anything more than superficial manifestations, just as physicians were handicapped in their examination of the heart prior to the introduction of the stethoscope and the electrocardiograph.

Within the past fifty years, however, conceptual tools and examinational techniques for getting below the surface have been discovered or invented. The vast additions and alterations to our knowledge regarding psychological processes and personality structure have not been reflected in our formal psychological examination. It is certainly time this was done.

The problem is to provide a systematic outline of procedure for obtaining (and later recording) data by all known methods of psychological investigation; this includes observations made by psychiatrists during the history-taking, the observations of the nurses and others who see the patient on the ward, the results of special psychological testing of many kinds, the reactions of the patient in interviews, the results of free association techniques involving temporary alterations of consciousness, such as the use of pentothal sodium and hypnosis. The findings of all these methods must be combined, and must be organized and recorded as objective, systematized data comparably to the way in which physical and chemical data are recorded. To do this in a meaningful way we need an outline drawn from, and congruent with, a theory of personality which is both systematic and broad enough in scope to enable us to pull together within a single coherent framework the many diverse observations that are gathered in the psychological examination. Such a schema we shall shortly submit.

The psychological examination comprises one part of a complete case study, along with other examinations and the systematic historical record. Like other examinations, the psychological examination presents a cross-sectional view of the patient as he appears at a certain time. The "time" will never be as brief a period as that of the physical examination both because the procedure is more time-consuming and because the processes are more fluid. Arbitrarily, therefore, one must set some such period of time as a week or ten days to be the "now" of the psychological examination. Thus, for example, if a patient under examination appears quite calm today, but is known to have been very excited a few days previously, the examination report is not accurate if it ignores the datum of excitement. This problem is really not so different from that of the physical examination as it seems; vomiting, for example, may never be observed by an examining physician, but evidence of previous

vomiting may be observable, and the reports of nurses are as valid for the examination as the observation of the physician.

Techniques of Examining

The psychological appraisal of a patient requires first of all that some kind of contact be established between examiner and subject. A psychological examination cannot be made adequately by mere detached observation like an entomologist studying a bug.

The taking of the clinical history is an excellent device for (simultaneously) getting facts and making observations pertaining to the psychological status; *i.e.*, the object of the psychological examination. But on the one hand it is not always possible to take a complete history in a case in which some psychological appraisal must be made, and on the other hand the taking of a history is rarely of itself sufficient for a complete psychological examination. Also required is adept, resourceful, flexible alertness on the part of the examiner—taking advantage of every cue, hint, lead, and trend detected in the patient's responses to the conventional gambits of social or professional conversation.

One proceeds from the known to the unknown. The examiner is an unknown; psychiatry is an unknown; Rorschach ink blots are an unknown. The weather, on the other hand (but the ingenious psychiatrist will probably not be reduced to so prosaic a common interest), is something known to both. Mutual acquaintances and interests, news events, even peculiarities of the room or day can be utilized. Gradually the voice and mannerisms of the doctor become less strange; the patient may begin to suspect that after all the doctor is a human being like himself. As such a beginning acceptance is established, more pertinent questions can be asked. It is not imperative to try to put the patient completely at ease—he may do better if permitted to ease himself. But tact is always in order; one must be as direct as possible without unnecessarily hurting the patient's feelings. If it can be summed up even approximately, the trick is to give the patient the encouragement he needs to believe he will be understood if he presents his real self and his main problem, and in the examiner's sympathetically following the patient's material, with a quick ear for departures from the standard "lines" and trends toward familiar psychopathological formulae.

It takes years of experience to acquire a skill in appraising the psychological status of a patient, but even experience will not sufficiently supplement a lack of sensitivity, intuition, gentleness, psychological penetration, and other qualities which it is difficult to describe. Furthermore, it requires plenty of time—several hours at the minimum. Routine history-taking will have furnished many data of examinational as well as historical value, but specific areas of psychological function will have to be examined which may never come into focus during the taking of a history. Having indicated his interest, and his humanness, the psychiatrist "moves in" closer. He takes another intrusive step; he asks questions, or proposes topics that take his patient and himself further into the core of the personality, behind the scenes, as it were. These questions are not for the purpose of gaining direct information so much as inferential information, and hence they should be worded in such a way as to minimize the effect of suggestion and avoid stereotyped replies. For example, it is better to ask, "How did you feel when you had to give up your farm?" than to ask, "Did you feel badly when you had to give up your farm?"

In general, a questioning attitude is better than a barrage of questions. The examiner may resort to indirect ways of questioning to elicit information about topics charged with anxiety about which the patient remains silent. The patient may resent direct questions which he may interpret as an assumption on the doctor's part that he is "crazy." If, on the other hand, questions pertaining to his psychic state are set in the neutral context of questions about his habits or illness, they are more likely to be accepted by the patient without resistance. Questions about difficulty in concentrating or lapses of memory may be embedded in the routine inquiries into occurrence of headache, tinnitus, or dizziness, without arousing anxiety. Routine questions about feelings of fatigue may lead into questions concerning awareness of changes in vitality, "pep," or mood.

One should always be cautious in eliciting information about psychotic symptoms, such as delusions and hallucinations and ideas of persecution. Questions should be phrased to inquire first about phenomena which are on the borderline of the abnormal rather than deep within its territory. If we ask a patient directly, "Do you think

someone is out to get you?" we usually evoke one of two responses. If the patient has no such idea, he will be annoyed; if he does have such paranoid thoughts, he may be put on guard and consequently, cover up his feelings. Instead, the doctor might very well begin his inquiry in this area by asking a question such as, "Do you think you have been treated fairly by your wife?" or "Do your fellow workers like you?"

On the other hand some patients need to be pinned down; their evasiveness and verbal dishonesty are themselves symptoms which serve to mask other symptoms. Tact and tenderness will rarely, for example, elicit the truth from drug addicts or even some alcoholics as to just how much they take, how frequently this occurs, how serious the consequences are. Unless one makes a vigorous effort to get this information, one does not discover how much resistance to treatment really exists. It is to be expected that some patients will "lie," but the examiner should not allow himself to be taken in and misled, any more than he will allow himself to be distracted into the blunder of scolding the patient.

Nothing has been said thus far about a most important, and still more penetrative, intrusive technique of obtaining psychological data; namely, the formalized test procedures (intelligence tests, projective tests, achievement tests). In their simplest forms, they can be used by the psychiatrist, but most are now so specialized and intricately developed that few psychiatrists are equipped either to submit the questions or to interpret the responses. Clinical psychology has gone far in developing these techniques with brilliant empirical results. The question constantly arises in modern group psychiatric practice when to utilize this method of psychological examination; *i.e.*, whether to refer a particular patient to a psychologist colleague for the obtaining and analyzing of these additional data.

Sometimes, it is true, additional data of psychological testing do not "add" anything. They may only confirm observations already obtained by the interview technique, or help the psychiatrist to organize better the data obtained by observation and history and interview. They may contradict the conclusions drawn from other methods, and present problems of different levels of inference.

The psychologist himself is frequently the best adviser as to

whether his approach should be one of clinical testing (and, if so, which tests be used) or one of interviewing. A properly trained psychologist should be quite competent to interview psychiatric patients and to take clinical histories with an eye to making a psychological examination without resort to testing. He may be less skillful at this than the psychiatrist, just as the psychiatrist is less skillful at testing—but he has had some training in it and should acquire experience. Correspondingly, the psychiatrist must acquire a general knowledge of the meaning and value of psychological test procedures, whether or not he adopts the technique of using them himself.

However the examination is made and by *whomever* it is made, the findings should be *recorded* according to a standard schema that embraces all psychological functioning, "normal" and "abnormal."

The novice may well ask, "Assuming that I have acquired some skill in getting *at* the patient's psyche, what do I look for? What do I examine? What data do I seek to obtain? What does my psychological examination tell me that the history and the other examinations do not? What *are* the 'known areas of psychological functioning' into which, as you have just said, I am to inquire systematically?"

Such questions are justified by the fact that until very recently no medical student was taught that psychological data are as important as physical or chemical data. All medical students are required to study physics and chemistry as "basic sciences"; but not psychology. Physical examination methods are carefully taught; clinical laboratory examinations are carefully taught. Psychological examinations are rarely mentioned. The day will come, some of us believe, when it will be as scientifically reprehensible for a doctor to omit psychological examination of a patient as to omit a urinalysis or an asucultation of heart sounds. But that day is not yet here.

Recording the Findings

The results of an investigation of the psychological functioning of a patient may be recorded in many ways. Different psychiatric hospitals and clinics have evolved their own formulae or systems; psychologists have evolved special forms for reporting test findings, and these, too, differ from place to place. In some clinics no formal

psychological examination report is prepared, a brief, impressionistic description sufficing. Indeed, some colleagues object on principle to any systematic recording of psychological data. Medical science faced similar objections when it was first proposed to percuss the outlines of the heart and record its dimensions. Said the older physicians, "Fie on this measuring of the heart with a centimeter rule! It gives a better picture to say merely that the man has a moderately enlarged heart." This does give a definite impression, but it does not give a precisely accurate description.

A psychological examination report is made up of a combination of raw data obtained by the examiner, inferences and conclusions from those data, and inferences and conclusions drawn from other data reported either by the patient or by others who have observed him, or by both.

Therefore, some schema for organizing and recording the various kinds of data will assist the examiner in distinguishing facts from inferences, and inferences from speculations. The theory of personality functioning, either explicit or implicit in such an outline, will facilitate the organization of data in meaningful terms.

The outline proposed in the following section attempts to bridge this gap by utilizing concepts of psychoanalysis, psychobiology, and other holistic theories of personality functioning. Since this is a manual of practical procedure, this chapter contains only the minimum of theoretical explanation necessary for understanding the various parts of the outline and their sequences.

Scope of the Psychological Examination

I. IDENTIFICATION

A. File number, age, sex, marital status, and other identifying characteristics of the patient.

B. Circumstances of the examination, including dates.

(1) Always state *where* and *when* the examination was made, and name those present. If any data used were obtained at another time by another person, such as psychological test results or the observations of a nurse, this should be specified. Give the date on which the data were organized into a formal record. (2) State whether the psychological examination was part of a total psychiatric case study or was a consultation service, to a surgical colleague, for example.

C. Special conditions affecting the validity of the findings.

For example, was the patient extremely reluctant to undergo examination? Had he taken any drugs which might have an effect on him at the time of the examination? Is the patient under sentence or awaiting trial? In case of paroxysmal or cyclic symptoms, how much time has elapsed since the last attack?

D. General impression conveyed.

The examiner's initial impression of the patient: gait, posture, clothing, voice, manner of speech, facial expressions, muscular tension, first reactions to meeting the examiner, general accessibility?

II. PART PROCESSES OF PSYCHOLOGICAL FUNCTIONING

The part processes of psychological functioning include perception and the reactions to what is perceived. These reactions are emotional reactions involving autonomic structures, striated musculature, and intellectual processes which slow and refine the immediate response tendencies to stimuli perceived. A patient may fail to perceive accurately or he may be distracted by perceiving too much; his memory may be defective or his ability to use it impaired. His emotions may be inappropriate or even lacking. By examining carefully how

accurately the patient perceives the outside world, how correctly he tests reality, how appropriately he reacts emotionally, how effectively he organizes his behavior toward his goals or fails to do so—we have a coherent picture of the intact and impaired areas in the patient's psychological functioning. The so-called "part processes" occur not in isolation, but in exceedingly intricate patterns of dynamic interaction. They all overlap. We are aware of these theoretical imperfections; our groupings are dictated by practical considerations including traditional usage.

The outline should not be used as a method of *making* an examination (although it may very well provide a conceptual framework for method), nor is it intended to be used as a questionnaire. For example, under *Perception, normal features*, one should not record "alertness, *yes;* accuracy, *no.*" However, in determining and recording the patient's perceptual functioning, alertness will naturally be considered; and, if it contrasts with his inaccuracy of perception, one might record: "The patient is alert to every move of the examiner, whom he consistently misidentifies as a nurse." There is no rule against combining such observations. They are separately classified in the outline, but only for the sake of logical clarity in reporting on a particular patient. It might well make for *unclarity* to segregate data arbitrarily under the various subheadings. If the examiner uses the main headings as his *primary* guide, and avoids following slavishly the subordinate ordering, his ability to present a clear and integrated picture will be greatly facilitated.

A. Perception (contact with reality)

Perception is the first step in reality testing—the discovery and identification of environmental and internal stimuli. Some use of memory and intellection is necessary for this identification, but the dysfunctions of memory and thought processes are deferred to the next section of the examination.

Normal Features: Alertness, accuracy, vividness, range, appropriate selectivity, reality assessment.

Deviations:

Deficiencies—*e.g.*, distractibility, disorientation (time, place, person), confusion, selective inattention, denial (*e.g.*, phantom limb), anaesthesia, anosmia, amaurosis.

Excesses—*e.g.*, hyperalertness, restless wandering of attention, hyperacusis, hyperaesthesia.

Distortions—*e.g.*, paraesthesias, illusions, disorders of body image, depersonalization, estrangement.

B. Intellection (cognitive reactions)

Once events and objects are perceived, they continue to be "studied" by processes of recollection, association, comparison and the like. In this clinical application, *thinking* might be compared with the use of a reference library. Before a person can react to what he perceives, he will automatically "consult" his memory of previous experiences. How orderly has this material been stored, how much of it is there, how available is it, how accurate, how coherent? We gauge what might be described as the *size* and *content* of the library, as well as its *utilization, i.e.*, the quantitative and the qualitative or functional aspects of cognition. In reporting on intellection, the examiner should avoid cluttering his report with details of raw data. We are not concerned here with how many serial sevens the patient is able to subtract, or with the circumstantial details of how he performed in tests designed to assess conceptual thinking. On the other hand, empty generalities such as, "The patient's thinking is concretistic," or "He shows poor judgment," should be documented by illustrations from the patient's speech or behavior.

The examiner should try to record what "occupies" the patient's mind in the ordinary sense of the word. What does he think about? What does he daydream about? What does he talk about? What does he ask questions about?

1. Content, level and range of intellection

Normal Features: Curiosity, memory, store of knowledge, range and type of ideas, fantasies, dreams, thoughts, intellectual level, special intellectual gifts, talents and skills.

Deviations:

Deficiencies—*e.g.*, stupidity, amnesia, hypomnesia, meagerness, vagueness, impoverishment, special deficits or developmental anomalies.

Excesses—*e.g.*, hypergnosis, hypermnesia, absorbing preoccupation (with plans, worries, fantasies), obsessions, fixed ideas.

Distortions—*e.g.*, memory distortions (in content or chronology), confabulations, gross judgment defect, delusions.

2. Functional aspects of intellection

Normal Features: Tempo (rapidity of association and ideas), rhythm (spontaneous, hesitant, halting), style (practical, simple, well-articulated or global, creative, inventive, reproduc-

tive), organization and logical coherence, direction, abstraction capacity, flexibility.

Deviations:

Deficiencies—*e.g.*, stereotypy, platitudinism, vagueness, rigidity, concretism, retardation, blocking, agnosia.

Excesses—*e.g.*, circumstantiality, over-intellectualizing, over-symbolization, syncretism, flight of ideas.

Distortions—*e.g.*, incoherence, irrelevance, condensation, contaminations, neologisms.

3. Language and communication

Since much of what and how the patient thinks is communicated in speech, writing, gestures and in other ways, his thinking as such should be distinguished from its expression or "tools." That the cognitive process has a sequence in which thoughts arise first and their expression or formulation comes second is an erroneous idea. Thought and language determine each other in such complicated ways that it is almost impossible to separate them, except in exposition. For this reason *language behavior* should come under the larger heading of intellection or cognitive functioning. Yet an assessment of a person's language per se can be of clinical value. Some people are glib and expansive in their speech; others are meticulous and their language is precise, sometimes halting, with incessant corrections and modifications. Words may have power and they may also arouse anxiety. Words and gestures may communicate or they may conceal one's thoughts. Silences may be highly communicative.

Normal Features: Fluency, diversity, and precision in speech and in writing, extra-lingual communication skills.

Deviations:

Deficiencies—*e.g.*, illiteracy, word paucity, stereotypy, clichés, vagueness, aphasic deficits, inarticulateness, circumlocution, semantic vagueness, agraphia.

Excesses—*e.g.*, garrulousness, over-exactness, pedantic or stilted word choice, verbosity, perseverations, redundancy, over-statements, excessive use of superlatives, over-affective, metaphoric or poetic language.

Distortions—*e.g.*, autistic word usage, neologisms, word salad, paraphasias, incoherence, jargon, glibness.

C. Emotion (affective reactions)

One should seek to penetrate the superficial aspects of emotion, and to report what the patient actually feels. Emotional processes are the most difficult ones to assess, because the subject may deliberately or unwittingly control or alter them. The examiner should not only describe the outward manifestations of emotion, but state his inferences concerning the patient's inner feelings and the observations from which these inferences are drawn (including facial expression, flushing, sweating, pupil dilatation, tremor, irregular breathing, and other muscle tensions). For instance, after describing a patient's mild euphoria, he might note: "The patient jokingly brushed aside the examiner's questions as to whether she ever felt blue, and seemed to want to create the impression that she is perfectly satisfied with the situation in which she finds herself. Yet, the very intensity and consistency of her striving, together with the rather wooden expression of her face during the infrequent lapses when she was not striving to be gay and animated, gave the examiner the impression that feelings of depression were not very far below the surface."

Emotions have an "ebb and flow" character; any specific feeling (as different in tone from other feelings) has a certain rate of acceleration and deceleration in the process of being built up and fading out. There are significant individual differences in this respect. The depth or strength of emotion, though very difficult to assess objectively, is also subject to individual variation. The concepts of *stability* and *lability* of affect relate feeling to the varying conditions of the person's external or internal environment. In some, emotions remain rather stable despite gross changes in surroundings, while others fluctuate rapidly from one extreme to another, even in relatively stable surroundings or inner conditions.

Normal Features: Prevailing mood, intensity and duration of emotional reactions, appropriateness, irritability, stability, lability, etc.

Deviations:

Deficiencies—*e.g.*, blandness, blunting, apathy, coldness.

Excesses—*e.g.*, prevalent or recurrent rage, depression, elation, fearfulness, apprehensiveness, jealousy, envy, suspiciousness, remorse, panic, sudden shifts.

Distortions—*e.g.*, inappropriate responses to stimuli, inappropriate guilt feelings, incongruity of feeling and action, dissimulation, negativism, facetiousness.

D. Action (behavior)

The report of psychological examination will contain not only the examiner's observations, but also the observations and conclusions of others who have been associated with the patient. This is particularly true in the record of the patient's behavior or *action*, since the examiner presumably witnesses only a small portion of the patient's day. The reports of nurses, aides, and adjunctive therapists should be fully utilized. Nor is it sufficient to note, merely, that the patient is "active in OT." Descriptive details of the spontaneity, drive, persistence and quality of his efforts should be stated.

Normal Features: Energy level, vigor, adroitness, directness, persistence, constructiveness, planning and timing, effectiveness, purposiveness.

Deviations:

Deficiencies—*e.g.*, clumsiness, inability to initiate action, inhibition, rigidity, apraxias, inertia, stupor, paralysis.

Excesses—*e.g.*, restlessness, hyperkinesis, agitation, assaultiveness, impulsiveness, destructiveness, gesticulation.

Distortions—*e.g.*, peculiar habits (eating, sleeping, smoking, excretory, sexual), tics and mannerisms, compulsions, rituals, posturing, stereotypy, catalepsy, aimless scattered activity.

III. INTEGRATIVE PATTERNS

Part processes establish and maintain relations between the individual and the environment. This involves continuous *internal* and *external* balance or integration. These balances are constantly changing, but in making the adjustments necessary for this balance, characteristic individual patterns and techniques develop. Most minor and many major changes (stresses) in the environment will be absorbed without much change in these established patterns. Stress that is too great, too sudden, or too long excites disturbing responses of disappointment, dissatisfaction, or aggression. These in turn impel the ego to use adventitious emergency devices which permit survival but are disagreeable, burdensome, and are symptoms of illness.

In this section of the examination, as in the previous major part, data are bound to include directly observed facts, reports by other workers, history obtained in various ways, and statements which may appear to be factual, but which are actually inferences. The degree of probability or correctness of an estimate or conclusion should be implied by the language in which it is recorded.

We assume each person is motivated by instinctual drives which lead him to explore his environment, to make selections and rejections, and in various ways adjust himself to what he finds. He is attached to others by bonds of interest, fear, desire, dependence, or envy. These can be reduced to various combinations and special aspects of *love* and *hate*, representing integrative and disintegrative instinctual trends. In some instances the love will far outweigh the hate, while in others the hostile and negative elements will far outweigh the love. Through these linkages there is a constant reciprocal interaction, although the quantities and patterns will never exactly correspond.

Every person relates himself to a number of other people, to material objects, to values, to society at large, to the universe and to his God. He develops certain attitudes toward himself and "his" illness. These relations make up his characteristic patterns of life adjustment. Integration is thus used in a double sense; the person becomes integrated with his environment to varying degrees and his psychological processes can be considered internally integrated if they have helped achieve a good external integration at not too great a cost.

A. Relations to other people

1. Range, diversification, depth, constancy and other general qualities of the patient's positive and negative attachments to people, prevailing techniques of social encounter, kindliness, friendliness, reserve, provocative challenge, quick empathy and identification.

2. Major attachments: the main figures in the patient's life, his best friends and his worst enemies. Indicate something of the quality of the attachment to them, *e.g.*, anaclitic, parasitic, possessive, intrusive, exploiting, companionate, erotic, or agapic.

3. General pattern of sexual adjustment (if not covered above).

4. Transference paradigm (relationships to examiner reflecting childhood patterns).

   The patient's general pattern of interpersonal relationships is frequently reflected in those he seeks to establish with the examiner. For example, he may be more anxious to please the examiner than to conform to truth; he may make innumerable requests and demands and take umbrage easily if these are ignored. Such approaches often typify the social techniques of the patient and one may make inferences about how they were developed in childhood situations. It may be helpful to describe these techniques in terms of roles.

B. Relations to things and ideas

1. Possessions

   How the patient reacts toward inanimate objects reflects his self-concept and his maturation. What does he prize most—his money, his car, his lands, his books? How does he treat them? How does he feel toward the possessions of others, *i.e.*, how sharp is his distinction between mine and thine?

2. Time and space

   Is time perception past-oriented? Future oriented? Narrow or broad? Habitually late? Always early? Procrastinating? Claustrophobic? Wasting time? Expansive?

3. Work

   Interest, intensity, variety, creativity, skill, efficiency; satisfactions with objects may be considered sublimations or useful fusions of destructive and creative impulses, the latter normally predominating.

4. Play

   Kinds, solitary or social, extent, satisfactions, sportsmanship.

5. Authority, power and responsibility

6. Philosophical, social and religious concepts

   Value system, philosophical attitudes and formulations regarding death, the existence of evil, race prejudice, religious belief.

C. Relations to self

1. Ego: Self-concepts, self-esteem, models of ego-identity, sense of freedom.

   The child originally identifies himself with the universe and only gradually subtracts from himself and accords autonomy to the various objects in his environment—first the mother, then the father, then toys or sky. We assume a core of self-investment of instinctual energies from which is drawn the supply necessary for external attachments. Some of this supply is in times of stress, pain, illness, or loneliness, returned to, or redirected upon the self as "secondary narcissism" (visible as self-love, self-pity, self-comfort), leaving less to neutralize the externally-directed aggression. This means that if one is sorry for himself, he will likely be more aggressive toward others. Under other circumstances, the aggressive component is redirected upon the self.

2. Ego-ideal: Level of aspiration, ethical standards, life goal formulation, sense of responsibility.

   This consists of that *complex of conscious attitudes*, evaluations, motivations, ideals and hopes that can be formulated in answer to the question: What kind of a person does the patient aspire to be? The feasibility of the aspirations, the motivating power or "steam" back of it, and the discrepancies between ego-ideal and everyday behavior are to be noted.

3. Super-ego: Evidences of strength, presumptive predominant models (if known), characteristic type of placation required (penance or penitence, mourning, physical suffering, gestures, deprivation, bribery), degree of externalization.

   This comprises those *unconscious determinants* of prohibition and obligations that are rooted in infantile identifications, the *"archaic conscience"* as distinguished from conscience in the ordinary sense. In reporting on super-ego functioning, the examiner must avoid psychodynamic speculations that have no place in a report of examination. Inferences should be confined to the available evidence. Since it is likely to be meager, the recorded data will probably be brief. Self-reproach, perfectionism, asceticism, and oppressive "oughts" and "musts" are common indices of super-ego over-activity.

4. The body: Attitudes toward body, body image, treatment of body, susceptibility to injury, sensitivity to pain.

   The body is certainly part of the self and yet in other aspects it is sharply differentiated from the self—we speak of *me* and *my* body, sometimes even of "it." The attitude of the ego toward the body may be one of over-estimation or under-estimation of nearness or distance. The "body image" each person has of his own appearance, his body conformation, his physical assets and liabilities, is always considerably different from how others see him. This discrepancy is frequently important and complicates the "relations" to the self, but there is a distinction between relations to the body as such and relations to the body as conceived.

IV. FAILURE OF INTEGRATIVE EFFORTS

Since adaptation is crucial to survival, the mode and degree of adaptation are basic determinants of a person's place on the health-illness continuum. All the holistic and integrative processes, as well as the part processes of psychological functioning, must be evaluated in terms of their efficacy in securing exchange between the person and his material and social environment.

If the characteristic patterns of integrative adjustment are suddenly threatened with disruption (*e.g.*, because of the death of a spouse, a crippling accident, a threat of injury, the loss of a job), the internal tension of the system, as perceived by the ego, may mount painfully high because of the activation of socially unacceptable impulses. Emergency devices are then called upon to reduce this state of psychological hypertension, or at least to prevent it from increasing even further, and threatening the integrity of the system. We know, empirically, what some of these regulatory or equilibrating devices are; in their lesser forms they are everyday mannerisms, substitutions and fictions. In more urgent situations they appear as symptoms.

The redistribution of energies made possible by the development of symptoms may enable the individual to re-establish or to develop new integrative relationships of a deviant (compromise) kind, which provide a measure of stability and comfort. On the other hand, we know that symptoms, while adaptive in the sense that they discharge tensions perceived as threatening to the integrity of the system, at the same time tend to *increase* tensions because of their disruptive effect on integrative relationships. Hence an equilibrium may not be achieved, and new and more severe symptoms may be resorted to before a semi-stable equilibrium is achieved.

The record in this part of the examination should provide an appraisal of the lengths to which the ego has been forced to go in its conservation efforts. Rather than indicating merely that the patient is "neurotic" or "psychotic" the report should show how much and in what manner the patient is disorganized.

A. Pain

The pain may be a consequence of direct trauma or it may arise from increased stress subsequent to trauma or even autonomously. Both the nature of the pain and its degree should be recorded. Its severity may not correspond to the degree of disorganization, but the very discrepancy is significant. (See Scale 1, p. 148.)

B. Injury to the Environment

1. Whether brought about by the patient's pain, his withdrawal, his neglect or his assault, the environment is likely to sustain some injury as well as the patient. The environment's suffering must be described and appraised and the particular parties injured designated.
2. The environment will react to its injuries and some of this reaction will be in the direction of the patient. Indicate whether the latter is basically hostile or sympathetic. Is the patient regarded as "crazy" or as "criminal"? Is the environment disposed to be helpful or punitive?
3. These reactions of the environment toward the patient will in turn excite a secondary reaction from him. Describe this. Does he understand it? Does he recognize his aggressive contribution? Does he care? Does he accurately interpret the way in which he is regarded by his environment? (See Scale 2, p. 150.)

C. Degree of Disorganization

As described at the head of Section IV, page 76, we consider that emergency devices are instituted in proportion to the severity of the disorganization threat. We distinguish four levels, based essentially on the degree of reality severance manifested. First Order emergency devices entail subjective discomfort and tension awareness but little or no reality denial. Second Order devices, primarily compensatory in nature are accompanied by a slight or moderate degree of reality detachment. Third Order devices comprise episodic explosions of marked dereism, followed by a resumption of quasi-stability and "normalty." Fourth Order devices comprise severe states of disorganization with persistent gross reality repudiation. (See Scale 3, p. 153, and the list of regulatory devices at the end of the chapter.)

D. Over-all Effectiveness and Social Façade

Some disorganized and inwardly uncomfortable individuals retain a surprising degree of social competence and continue to function in their work and daily lives with little or no public detection of the handicap. This façade must be regarded as a coping device of variable usefulness. It may be a great asset or a great liability. The suffering of some individuals may be known only to their psychiatrist if to anyone. But likewise the dangerously explosive aggressions of some individuals may be masked by a façade which enables them to elude detection. Despite the imperfections of our technique of investigation in this area, the examiner should make an attempt to appraise the façade carefully. (See Scale 3, p. 153.)

V. RECAPITULATION

Summarize briefly in telegraphic or tabular style the significant findings of the psychological examination, including the intact functions which can serve as assets for therapeutic exploitation, as well as the important pathology.

WORK SHEET

The following pages reproduce a practical schema for making notes during the course of interviews along general lines of the schema for the psychological examination outlined above. This is similar to the worksheet for recording clinical history data presented on pages 41 to 44, and the reader may wish to refer back to the discussion of its use on those pages.

THE MENNINGER CLINIC
Psychiatry and Neurology

Psychological Examination
Data Sheet

Name_____
Age_____ File No._____
Dates_____
Examiner_____

Circumstances

Place

Legal status

Initial impressions

Appearance

Accessibility

Reaction to examination

General statement of the problem

PART PROCESSES

Perception

Alertness
Accuracy
Range

Disorientation
Distractibility

Hyperalertness
Hyperaesthesias
Paraesthesias
Hallucinations
Depersonalization
Body image changes

Thought content

Knowledge
Range
Fantasies
Dullness
Amnesia
Impoverishment

Hypermnesia
Worries
Obsessions
Delusions

Thought processes

Tempo
Inventiveness
Flexibility

Concretism
Rigidity
Blocking
Impulsivity

MF-12B (7-61)

CHART 5

Thought processes

- Over-intellectualizing
- Circumstantiality
- Flight of ideas
- Fluidity
- Other

Language and communication

- Articulateness
- Precision
- Conceptual level
- Non-verbal communication

- Pressure of speech
- Autistic word usage
- Grammatical misconstructions
- Neologisms
- Incoherence

Emotion

- Prevailing mood
- Appropriatenesses
- Range
- Intensity

- Apathy
- Coldness
- Shallowness

- Excesses or distortions
  - in range
  - in quality
  - in intensity

Action

- Energy level
- Persistence
- Effectiveness
- Organization

- Restlessness
- Impulsivity
- Overactivity
- Aggressiveness
- Destructiveness
- Inertia
- Inhibition

- Peculiar habits
- Mannerisms
- Compulsions
- Posturing

INTEGRATIVE PATTERNS

Relations to others

- Range
- Depth
- Constancy
- Satisfactions
- Major attachments
- Sexual behavior patterns
- Transference paradigms

Relations to things and ideas

- Possessions
- Time and space
- Authority, power and responsibility
- Value system
- Work
  - amount
  - effectiveness
  - intensity
  - satisfaction
- Play
  - amount
  - skill
  - intensity
  - satisfaction

Relations to self

- Self-image
- Body-image
- Identity-models
- Aspirations
- Self-dissatisfactions
- Self-directed aggressions

Relations to present situation

- Discomfort experienced
- Discomfort inflicted
- Concept of illness
- Concept of recovery
- Attitude toward examiner

Relations to reality

- Common sense
- Reality testing
- Reality adherence

RECAPITULATION

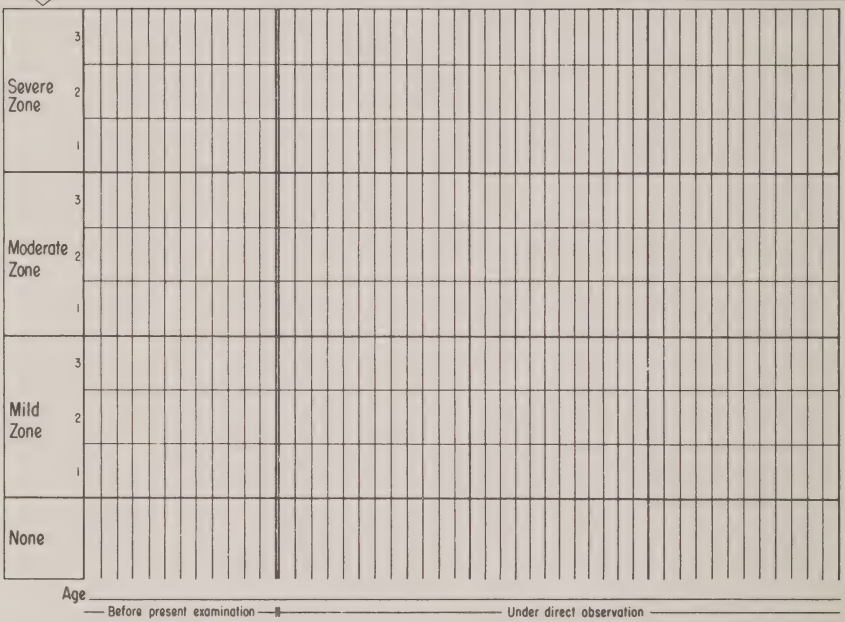
Intact functions

Outstanding pathology

Degree of Illness

PRESENT ILLNESS GRAPH

Patient's Name _____
Date Period _____



Circumstances

Examiner_____M.D.

Catalogue of Reactions to Stress

A. *Normal regulatory devices of everyday life adjustment*

Reassurance by touch, rhythmic motion, soft sounds and speech
Nursing, eating, smoking, chewing, drinking
Proud self-discipline (for inner and also outer approval)
Laughing and crying
Boasting, strutting
Falling asleep
Talking it out, praying
Thinking
Moving (pointless muscular activity)
Exercise
Acting to alter
Fantasies and dreams
Parapraxias, including swearing
Symbolization
Reaction formation and the counter-phobic mechanism
Re-enactment
Somatic expressions

Any of these may be over-used to constitute a first order of pathology.

B. *Regulatory devices characteristic of a first order of disorganization (pathology)*

Hyper-suppression (conscious effort at self-control)
Hyper-repression (inhibition)
Hyper-vigilance
Hyper-emotionalism (tears, overgaiety)
Hyper-kinesis ("restlessness")
Hyper-intellection (worrying)
Hyper-compensation (denial)
Minor somatic and sexual dysfunctions

C. *Regulatory devices characteristic of a second order of disorganization*

1. Aggressive discharge blocked or disowned by dissociative withdrawal
   - fainting
   - brief dissociation
   - sleepwalking
   - phobias and counterphobic states
   - obsessional thinking

2. Aggressive discharge displaced to substituted love-objects
   - temper tantrums
   - vandalism
   - projection and paranoid attitudes
   - lying and deception
   - malingering
3. Aggressive discharge displaced to the body
   - self-imposed restriction and abasement (asceticism)
   - body mutilation (self-inflicted, "accidental" and surgical)
   - self-intoxication or narcotization
   - somatic involvement (fantasy, sensation, function)
4. Aggressive discharge effected through symbolic and magical modifications
   - rituals and compulsions
   - kleptomania, pyromania, etc.
   - undoing and restitutive gestures
   - obsessions
   - perverse sexual modalities

D. *Regulatory devices characteristic of a third order of disorganization*

1. Directed (episodic) aggressiveness
   - sociopathic patterns ("crime" etc.)
   - psychopathic patterns ("vice" etc.)
   - impulsive violence (catathymic crises)
2. Diffuse (episodic) aggressiveness
   - panic and demoralization attacks
   - "schizophrenic" episodes
   - "manic" episodes
3. Unfocused (episodic) aggressiveness
   - convulsions and seizures
   - organic syndromes
   - dancing mania, tarantism, etc.

E. *Regulatory devices characteristic of a fourth order of disorganization*

Extreme melancholy ("depression," "thymergasia," "affective disorders")
Erratic, disorganized excitement ("delirium," "dysergasia")
Autistic regression ("parergasia," "hebephrenia")
Delusional preoccupation ("paranoia")
Amnestic states with disorientation, confusion, bewilderment
Basic defect states ("oligergasia")

CHAPTER IV

Diagnostic and Prognostic Conclusions

In making a psychiatric case study we follow the classical scientific method of first *collecting* data, then *arranging* them and *recording* them in some organized structure. These three different processes may go on almost concurrently. The order of collecting the data, except for those of the psychological examination, usually follows a systematic program which automatically provides for a kind of organization. In the course of recording data, various conventional schedules are used, so that the data are arranged according to chronological sequence, contiguity, physiological relationship or some other principle.

But this is not organization enough to constitute or make possible a diagnosis. What it gives us is several packets of data about a patient; data of different kinds, related but not integrated. We have a condensed biography, a kind of written picture of his present physical status, and a description of his psychological functioning. The historical or longitudinal view has supplied certain data to be correlated with the data obtained by the cross-sectional view, the examinations. Both kinds of data have been obtained as the result of a relationship established with the patient and those about him. The patient, hoping for certain benefits to himself, submits himself to our observation and gives what he can to the mutual process which is, in the last analysis, a search for the proper treatment.

To arrive at a decision regarding the best treatment for a particular patient, the data of the historical and cross-sectional studies must be added up purposively. They must be organized, synthesized and integrated. These pieces of undigested information must be arranged to form a symbolic representation of a patient's life process, including his recent failure or "illness". Since this life process is one of interaction between one organism and many, between one organism and the world surrounding it, we must also know something of this world. A continuous process has been going on for some time, and since the interaction has been—of late—con-

spicuously unsatisfactory to someone, we must carefully examine this phase. But we have to look at more than the troublesome areas; we have to see as much of the life picture as is relevant to the correction of the troubled areas and of the deflection from desired goals. And we have to look at these in the frame of some model or concept of what the life process is.

The individual who is now our patient was once the patient of an obstretrician, who handed him over in time to a pediatrician. The nucleus of the personality present at birth, that combination of hereditary and congenital items which suddenly appeared, was acted upon and interacted with many changing features of the new world. First there was a little world of mother and brother and rattle and bottle. The larger world beyond them—a room, rooms, grass, trees, sky, people—gradually took shape. This growing personality, with the aid of parents and peers and teachers, ultimately discovered and explored more of the various environments about him—some intimate, some proximate and some more remote. He established relationships with parts of these environments, and to some extent changed them. By this he himself was changed, and his change again affected the environment. Each continually made new requirements of the other, but certain habits and balances and expectations became established. If these were occasionally upset by unexpected events, they were shortly re-established in the main, and "life went on".

Most contacts between environment and individual are pleasant or at least tolerable; some of them are necessarily painful and intolerable. The environment of the particular individual under study may have seriously injured or crippled him, intentionally or otherwise; he, in turn, may have seriously damaged or inflamed parts of his environment. Some situations are easy to overcome, some are mastered with difficulty, some are overwhelming. Accidents and fortuitous events keep occurring which rupture patterns of adjustment so that compensations and rerouting have to be made.

We used to say that to diagnose an illness we should endeavor to discover what the patient has to react *with*, what he is reacting *to*, and *how* he is reacting. The conclusion of a diagnostic case study according to this formula might be: "The patient *has* a schizoid personality, *with* which he reacts to a demanding wife by *retreating*

into schizophrenia." This kind of diagnostic statement is a great improvement on the kind of diagnostic statements prevalent in earlier days of psychiatry, such as: "The patient is insane and committable; he has dementia praecox, hebephrenic type." And such a diagnostic statement as the latter is in turn better than the still older diagnostic statements to the general effect that "The patient is out of her mind; she is a lunatic; she is bewitched." It was a step forward to recognize that these pictures actually represent not different diseases, but different forms of one disease. Emil Kraepelin, dismayed by the vast numbers of variously labeled syndromes, attempted to bring order out of the chaos by a shrewd and arbitrary grouping of symptoms, considering their evolution over long periods of observation. This was useful in reducing psychiatric designations from thousands to a few score, and Kraepelin's exquisite designations and convincing delineations gave his taxonomy great popularity and influence.

Adolf Meyer, who introduced Kraepelinian psychiatry in America, later did his best to reject and extrude it. He tried to supplant it with the concept of mental illness as an undesirable reaction to environmental stress, capable of being described in terms of inept energy expenditure of different kinds. As a result of his efforts and those of William Alanson White, American psychiatrists began to ask, not "What is the name of this affliction?" but rather, "How is this man reacting and to what?" This led, of course, to the third logical question of a triad, "What does he have to react with?" This, in turn, led to the formula described, "With what, to what and how?" But gradually this had to be amended. For instance, just what is implied by the question: "What does one have to react with?" Almost simultaneously in a dozen places psychologists (and a few psychiatrists) began to be concerned with a systematic and consistent theory of personality. At the time Freud began his work and, indeed, until a few decades ago, there were few books about personality *theory* and, indeed, few systematic theories. But suddenly treatises on personology began to appear—Lewin's in 1935, Allport's in 1937, Murray's in 1938, and after that Goldstein's, Angyal's, Sheldon's, Cattell's, Dollard's, Sears' and Gardner Murphy's.*

* These and other theories have been analyzed competently by Calvin S. Hall and Gardner Lindzey in their *Theories of Personality* (New York, Wiley, 1957).

Case study method had to be enlarged not only in respect to the reaction capacities of individuals, *i.e.*, according to some theory of personology, but in regard to the reactions produced or observed. More and more careful psychological and physiological and anatomical examinations began to be made. Just as progress has been made since the days in which a physical examination consisted in taking the pulse and temperature, so, similarly, great progress has been made in the techniques and scope of the psychological examination since the days when our chief preoccupation was to discover whether or not the patient was "oriented" or professed hallucinatory experiences.

Finally, the "to what" element of the diagnostic triad has undergone much change. Freud's discoveries demolished for all times the easy assumption that human reactions are ever to *one particular more-or-less obvious thing*. Reactions are always to more than the one person or event. True, the event may be overwhelming, such as a blow on the head, but even such events are never entirely disconnected from the other events and persons in the universe or from the memories and the previous experiences and conditionings of the patient. The older state hospital legal forms used to require that "the cause" be identified in the case of each patient admitted. It is amusing to find in these records long lists of such things as "alcohol", "masturbation", "meanness", "deserted by husband", "loss of virginity", "financial difficulties", "business failure". It may be taken as axiomatic that psychiatric illness always represents multiple and complex reactions to multiple factors—factors in the body, in the environment, in the memory, even in the imagination. Established equilibria are disturbed, self-regulation is impaired and disorganization of the internal government is threatened. This view of mental illness has replaced the older simple cause-and-effect "reaction" concepts.

But this view requires new names, new terms, new ways of describing. In the example just given, the word *schizophrenia* is used to describe a patient's way of reacting. In the opinion of many of us it does so inadequately. Guiteau, who shot Garfield, was thought by some to be "reacting by a retreat into schizophrenia"; but the same has been said of Joan of Arc, some famous artists, many patients in state hospital back wards, and many shy and often

creative boys and girls in high schools and colleges. The International Congress on Schizophrenia, held in Zurich in 1957, brought together psychiatrists from all over the world, abstracts of whose presentations fill four volumes of small print, a total of 1828 pages!* The conclusion of it all is that there are hundreds of different things called schizophrenia and understood to be schizophrenia by different doctors. The use of such a word is thus of little use; our opinion is that it does a good deal of damage.

". . . Many terms—some diagnostic, like schizophrenia, others nondiagnostic, like libido—function as panchrestons (a meaningless explain-all word). 'Schizophrenia' is supposed to 'explain' so-called insane behavior in much the same way as 'protoplasm' explained the nature of life, and 'ether' the manner in which energy travels through space. Not only do these words *not* explain the phenomena in question, but, as Hardin rightly emphasized, they hinder understanding and explanation. If this is so, it means that just as 'ether' and 'protoplasm' obscured important problems in physics and biology, so 'schizophrenia' (and many other psychiatric words) may obscure fundamental problems in psychiatry . . . From a point of view of psychiatric nosology . . . categories such as 'schizophrenia' may be doubly harmful."†

Empirical clinical psychiatry, with the aid of clinical psychology, recognizes the tendency of certain psychopathological manifestations to occur in clusters. For example, with heaviness of spirit, emotional depression and self-reproach one frequently finds a slowing of thought processes, but usually *not* (for example) visual hallucinations or convulsions. In the incoherent, rambling verbal productions of delirium one usually does not hear echolalia or neologisms. Hence the careful study of the *classical syndromes of psychiatry* and of the pathologic indices discovered by clinical psychology research is a necessary part of the psychiatrist's diagnostic equipment. He must know the common associations of symptoms. But he must go beyond this. He must try to understand the meaning of these symptoms, their specific or dynamic meaning, and their function, *i.e.*, their usefulness.

* *International Congress of Psychiatry,* Congress Reports, 4 vols. Zurich, Fussli Arts Graphiques, 1959.

† Szasz, Thomas S.: The Classification of "Mental Illness." *The Psychiatric Quarterly,* 33:93, 1959.

Think of the human organism as a system belonging to outer systems and containing inner systems, all of which are interrelated. Obviously, there must be some kind of internal direction and control. These are functions labeled or ascribed to "the ego."* And just what is it that is directed and controlled? One cannot say that it is the reaction to external stimuli without assuming that there is something that impels the reaction. The Freudian dynamic concept is that the human organism is driven forward by a pair of interacting drives tending to bring the individual into relationship with the rest of the world either constructively or destructively. It is as if each individual were armed in the one hand with a sword and in the other with a bouquet. It requires great art to combine the use of these two skillfully, safely and productively.

Ego functions are numerous and complex. They are most apparent in controlling and directing the instinctual forces just mentioned. But in order for these functions to operate, the external world must be perceived, past experiences of the organism remembered and the stipulations of the peculiar formation known as the conscience heeded. Thus the ego must have at its disposal both internal and external radar equipment, with complex receiving and recording apparatus. In some extraordinarily competent way, the ego weighs the information received from all these sources and undertakes the reconciliation of the various pressures—instinctual, autistic, superego, external threats and dangers, external invitations and possibilities.

All of this implies a considerable tension which has to be kept at an optimal point. If the tension drops too low, the individual ceases to strive and accomplishes nothing, perhaps not even his own preservation. On the other hand, if the tension becomes too high, there is pain and a compulsion to "do something" lest this little universe explode, as larger universes have done. Assuming that the ego has some sense of self-preservation, we expect a threat to the integrity of the organism to be met with emergency measures instituted by the ego. Unexpected events are always occurring and for these there have to be *ad hoc* solutions. A situation may be corrected

* Language is such that we get to speaking as if the ego were a detached body, in some way or other incorporated into the organism to do this work. If one remembers that this is a figure of speech, it will do no great harm.

by taking certain steps, but whether or not it is corrected, an increase in tension will occur and may be perceived as discomfort.

The special devices employed by the ego for organismic survival under circumstances of overstress are known as symptoms. Some symptoms are merely signals of the fact that further devices are needed and other symptoms report that an emergency device is in operation. The noise made by air going out of a punctured tire, for example, is a physical illustration of the former; the bumpy sound caused by running over a patch that has been applied is an illustration of the latter. Both of these would correspond to symptoms because they are not "right." They are somewhat uncomfortable and expensive and unwanted.

Once all symptoms were thought to be meaningless *except* in the sense that they were signals of distress or evidences of dysfunction. Through his studies of the unconscious, Freud enabled us to see that symptoms often had definite concealed symbolic meaning. The fear of high places turned out to be, in some cases, an unrecognized ambitiousness; the senseless hatred of a certain individual proved to be a mask for love.

The dynamic understanding of symptoms as expressing intentions of the organism helped us to get a new view of the strivings and stratagems of the unconscious depths of the human personality. But it did not do full duty to the utility of the symptom. The symptom not only has meaning; it has function. It it an effort toward stabilizing and preserving the organism. And hence it is an indication of how the battle of life is going.

We would say, then, that the psychiatric patient, no matter what his symptoms may be, *i.e.*, no matter what he does (and this includes some pretty bad behavior), is doing the very best *he* can unassisted. This is the way his ego deals (dealt) with what seems (seemed) to it to be an impending crisis. The solution was not good enough, we grant; it may not satisfy anyone, not even the ego. In fact, this very dissatisfaction of the ego with what it has been able to do—and not do—may be what gets the patient to the psychiatrist. With a little help, a little rest, a little advice, a little external restraint, some corrected misinformation—the ego may be on its feet again, dismiss its emergency devices or employ them more skillfully and resume its level of achievement, perhaps do even better than before.

This is why we emphasize the careful examination of how the battle is going, the trend of the illness. Taking a long view, one looks for previous occurrences of disability and unsatisfactory adjustment. Perhaps there were none, or perhaps there were minor flurries of maladjustment at various times, never severe enough to be called illness. But five years ago or three months ago or last week a different sort of thing made its appearance. It was more disturbing; it was more painful; there was more reaction on the part of the environment or of the patient, or both! And whether matters have gotten better or worse since then, this exacerbation led up to the case study that is now in process.

Or, again, the life history of the patient may have shown several severe illnesses, periods of failure, or retreat, or belligerency. There may have been a long, continued maladjustment of a moderate degree. Even while the case has been under observation changes may have been noted.

Such things can very well be charted—not with pinpoint accuracy, of course, but approximately enough to make possible a graphic record of the life adjustment, its level of satisfactoriness or healthiness. It is helpful to plot a graph of this kind, using some such scale as the one shown in the charts on the following pages. Adolf Meyer used to require a graph of a similar kind for all his patients. Our charts provide for a low-power, long-range graph for the life history, and for a high-power, shorter-range graph on which to bring out the fluctuations of the present illness.

Conclusion of the Diagnostic Process

The psychiatric diagnosis then is not the ascription of a name to a group of symptoms but a complex set of conclusions: descriptive, analytic and evaluative. It describes an environment and an individual and their interaction, with particular reference to an unsatisfactory kind of interaction which has developed and which is seen in the patient in a certain form. A psychiatric diagnosis is always polydimensional, multidisciplinary and continuous. Theoretically, therefore, it cannot be recorded, because no sooner has a description been entered upon a case record than it begins to be out of date. The process goes on, the picture changes; but the written designation remains fixed. Nevertheless, not to make a record would

be even more incorrect and improper. But the quality of change must be recognized, and the description or diagnostic formulation dated. Then it must be revised and amended and kept up to date in accordance with the physician's observation of clinical and environmental changes. In this sense progress notes constitute supplementary diagnostic conclusions.

In the schedule for the written formulation of a diagnostic statement (see end of this chapter), it will be observed that an appraisal of the environment is followed by an appraisal of the patient. Some suggestions are made regarding the environment and, similarly, regarding the patient. The latter consist of somatic investigations and psychological investigations.

Both somatic and psychological investigations will discover certain assets possessed by the patient which do not ordinarily constitute a part of traditional diagnostic description. Because of their importance in any psychiatric treatment program, however, they should be noted.

The pathology discovered should be described and recorded clearly. It is easier to write "Hodgkin's Disease" than to record a repetitious description of "Disseminated lymph node enlargement, especially cervical, etc., etc." Similarly, it is easier to say that an individual has always been withdrawn, seclusive and eccentric than to write a paragraph describing his premorbid personality structure. The adjective "schizoid" is often used for a still further condensation and abstraction, but it tends to become jargon, incomprehensible to some and used differently by different colleagues and incomprehensible to the uninitiated. Hence, use with caution.

The most conspicuous aspect of a patient is his symptoms, the evidences of his difficulties in adjustment. Some of these symptoms represent his pain and his efforts at achieving some degree of relief; other symptoms will represent efforts at salvaging the situation, preventing further disorganization and putting a good face on the matter. In all this we see a stage of disorganization—not a complete one but a partial one. In the Diagnostic Summary there should be a definite statement about this disorganization. We have already listed some of the symptoms and perhaps even the syndrome they add up to. Next we must state how successful the symptoms have been, so to speak; how severe is the disorganization, which means not only how far is it from normal but how far is it from complete

disintegration. Furthermore, which way is it going; is it progressing or is it receding? Is the patient getting better or is he getting worse, or is the process at a standstill? If not at a standstill, is change occurring?

Finally, it is necessary to explain as well as we can how this all came about. This explanation should be written with a minimum of technical jargon and should endeavor to interpret the illness as seen in the light of background and environment in some logical way. It is not enough to say that a patient has a schizophrenic syndrome; why does this patient have the symptoms of that syndrome at this particular time, and what can we expect? This is what relatives and referring physicians and judges and others want to know. This formulation may be essentially genetic, *i.e.*, concentrated on the relation of early life factors which made the patient vulnerable to certain stresses, or it may be dynamic in the sense of analyzing the sequence and potency of the recent stresses, or it may concentrate on emotional and somatic interactions. The emphasis will differ in different cases, but the object is in all cases to explain as well as possible the relations of the various kinds of data to each other.

One might say of a certain individual, for example, that the record shows he came from an impeccable family background and had an uneventful childhood and adult life, but developed poliomyelitis in college which so impaired his general social and athletic adjustments that he became increasingly tense, depressed and inactive, and recently attempted suicide. The examinations show that he is less physically disabled than he believed himself to be but is, on the other hand, moderately disorganized with a trend toward reconstitution.

Or: "The patient was born on a farm in Nebraska of first-generation French-American parents. The mother refused to learn English and died when the patient was ten. This caused severe difficulties in identification for the child, who rejected his father's efforts to be affectionate and protective and who set out on a self-determined, self-supporting career which was moderately successful. Moderate tension seemed to have developed upon the occasion of his marriage at the age of 27. Three children were born to the couple. The home has been turbulent and the marriage unstable. A threat

of divorce by his wife precipitated a period of acute excitement in the patient, presumably related to the emotion felt by him at the time of his mother's death. A rapid disorganization followed, with an appearance of hallucinations, delusions, and threatening behavior. Hospitalization was immediately obtained and a slight recession in symptoms is apparent in this, the fifth day of observation."

Thus, the illness of each individual has to be studied *de novo*. We re-examine the history to discover the course of previous attacks. We examine the general form of the illness to discover whether it has a tendency toward cyclic recurrence or episodic appearances.

Then we most carefully examine this particular illness. Perhaps we graph its development on a chart. We are not only concerned with whether the severity of the illness is increasing, but also with whether the *rate* of exacerbation is increasing. Moreover, we are concerned with the conditions which gave rise to these recent changes in the life course chart. We need to know whether the patient is reacting to a set of factors as he did in the past when confronted with the same factors, whether he is reacting differently to a similar set of factors, or whether his life circumstances which figure in the most recent illness are significantly new and different ones. All of these indicate the direction in which we may extrapolate the subsequent life course chart, which is what we mean by prognosis.

Treatment, however, has already begun. The case study itself is a step in the treatment. (Not the first step; bringing the patient to the doctor, for example, must be considered a step. Getting him hospitalized is another.) The effect of the case study itself upon the patient is always carefully considered by the observant psychiatrist in formulating a prognostic statement. We sometimes see instances in which the patient is cured by the examination alone (often to the doctors' astonishment)! Unfortunately, this is usually not the case. But we do expect to see some new kinds of expectations develop in the patient.*

* This is what Thomas French calls the activating force in the integrative function of the ego. It is not quite the same as my view of hope. (*The Integration of Behavior*, 3 vols. Chicago, University of Chicago, 1952.)

These expectations usually occur in response to the doctor's treatment recommendations, or to the initiation of a treatment program. The treatment program itself is based upon the antecedent diagnostic study just as are the prognostic inferences. It represents the considered opinions of the doctor concerning those internal and external factors which require change, and those which are most open to change, and the most efficacious way to accomplish these changes. But even in the shift from observation to treatment, the initial diagnostic study is still incomplete without an explicit review of the dynamic factors which determine, or co-determine, the probable outcome of any treatment effort.

Considering first those forces or circumstances which seem to work *against* improvement, one asks oneself such questions as these:

(a) Are this patient's prospects for improvement pre-limited by unalterable factors such as organic defect, developmental lag, advanced age, progressive physical disease?

(b) Are the patient's prospects for improvement impaired by conditions unlikely to be altered, such as irreparable loss, psychological rigidity, various physical diseases, actual guilt or realistic economic and other fears, legal entanglements?

(c) Does the patient's life history indicate that his aggressive impulses are extremely difficult to deflect, modify or placate?

(d) Is the patient's narcissism so extreme as to preclude capacity for object attachments? (This usually occurs after an extremely severe psychological injury in infancy and tends to preclude effective therapeutic relationships.)

(e) Are the indirect satisfactions from the illness notably in excess of the price paid for them in pain, popularity, etc. (*i.e.*, is there conscious motivation for therapy)?

(f) Is there conscious acceptance of self-destructive intent?

(g) Is a patient's home or other "ultimate" environment to which the patient returns frustrating, corrupting, or otherwise harmful?

Concerning the forces and factors which seem to be on the side of recovery, working *toward* improvement or capable of being exploited in therapy, one asks oneself such questions as these:
which seem to be on the side of recovery, working toward improvement or capable of being exploited in therapy, one asks oneself such questions as these:

(a) How much does the patient's pain (anxiety, apprehensiveness, depression, guilt feelings, excitement, shame) motivate him to seek a more favorable compromise? *Cf.* item (e) above.

(b) Opposed to the positive pain referred to in the question above, how much does he sense painfully the loss of satisfaction?

(c) A large factor in treatment depends on the patient's intelligence; how well endowed is he in this respect? How accessible to reason, re-education, counsel is he?

(d) Does he show some propensity for acquiring and using transitional love objects—other patients, aides, nurses, physicians, others?

(e) Are there latent capacities for recreation, and if so, are they likely to be narcissistic, libidinous or aggressive expressions?

(f) If self-punition is a marked feature in his symptomatology, is it susceptible to the substitution of symbolic forms of penance or realistic restitution?

(g) Is there evidence of undeveloped potentialities for creativity and healthy living?

(Items c,d,e,f, and g above imply the presence of intact areas of functioning which might be extended by and through treatment.)

(h) Is the home situation or other "ultimate" environment to which the patient returns attractive to him?

(i) Is the patient's temperament essentially optimistic or pessimistic? (*Cf.* Erikson's "basic trust-mistrust" concept.*)

Many of these questions can be answered only on the basis of conjecture and indirect evidence. Improved accuracy in weighing them comes with experience.

But such a balancing of positive against negative forces is more specific than general approximations of "ego strength" or "ego weakness"; the latter expressions come to be used as if the quality of strength were something special or specific which could be acquired or lost. This metaphor were better replaced, in our opinion, by an operational examination of ego functions such as we have outlined. The essence of the matter is that we must weigh those factors which help the patient, or help us to help the patient, or help us to help the patient help himself, against those working in the opposite direction. The trend of this and previous illnesses together with this analysis will give us a basis for saying what we can expect from our efforts with this particular illness of this particular

* *Childhood and Society.* New York, Norton, 1950.

patient. Any prognostic statement must be expressed in terms of degrees of probability. It would belie the humility appropriate to science for it to be otherwise. No one actually knows about the future. We can only say what the trend seems to be, and the point we believe might be reached under available circumstances of treatment.

Psychiatrists usually take for granted what almost no one else assumes, namely, that their patient can (and perhaps will) recover from his illness and be healthier than he ever was before. Sometimes the failure of the patient to preserve or believe in or make use of his latent potentialities saddens or exasperates the psychiatrist. But sometimes it is the psychiatrist who does not perceive these latent powers.

Few cases can be described as definitely and completely hopeless. To be sure, many psychiatric patients progressively deteriorate until the illness terminates in death, and many more cases fluctuate uncertainly without achieving stabilized improvement. On the other hand, statistically, the great majority of patients with psychiatric illness recover. The reasons this sounds contradictory are, first, that one forgets the very high incidence of psychiatric illnesses and the probability that most of them are never seen by any physician; and secondly, one forgets that many psychiatric patients, in and out of hospitals but seen by physicians, get well so quickly that they are not ordinarly visualized as a part of the long-standing hospital load. We must believe, therefore, that the trend toward recovery is perennial. It is obvious that we assume this; if we did not, if we did not believe the outlook for our patients in general to be favorable, we would not be offering a treatment program. Diagnoses were once made largely for diagnosis' sake—for taxonomies, for statistics, for administrative uses. Today they are made primarily for treatment planning.

RECAPITULATION OF SUMMARY CONTENT

A. *Appraisal* of the ENVIRONMENT

1. The general environment of the patient's life adjustment (national, social, economic, geographic, etc.)
2. Characteristics of the more immediate environment (neighborhood and family)
3. Environmental factors particularly injurious or over-stimulating to the patient or particularly supportive to him
4. Injuries to the environment *by* the patient, and its reactions thereto; also any particular contributions to it from the patient

B. *Appraisal* of the PATIENT

1. *Somatic* structure and functions
   a. Physical *assets* of note
   b. Physical and neurological *pathology* (use standard nomenclature and give date)
2. *Psychological* structure and functions
   a. *Assets* and potentialities; character traits; prevailing façade
   b. *Impairments* and liabilities
      (1) In the established personality structure
      (2) Present disorganization (diagnosis in the old sense)
         (a) Degree (mild, moderate, severe)
         (b) Type (acute, chronic, episodic, recurrent)
         (c) Trend (increasing, decreasing; slow, fast)
         (d) Syndrome (most nearly appropriate APA designation)
         (e) Symptoms and signs (or refer back to II-B-4)

C. EXPLANATORY FORMULATION: Genetic, developmental or dynamic

D. PROGNOSTIC estimate

E. TREATMENT recommendations

CHAPTER V

Treatment Recommendations

THE OBJECTIVE of diagnostic case study is the appropriate treatment for a particular patient. This treatment has to be *planned.* All during the course of making a case study, and particularly as the findings are reviewed in the course of constructing a diagnostic synthesis, the experienced psychiatrist is automatically formulating plans in the back of his mind, for the treatment. In bringing the patient and therapeutic agents together, there are questions of selection, timing, resourcefulness and economy. This requires art; it requires experience; but definite scientific principles lie back of it and these must be learned.

First and always the psychiatrist must see his own position clearly. He begins—in every case—by being an outsider, a referee to whom an appeal has been made. This role shifts in the course of the diagnostic studies. Already a part of the environment, the doctor becomes a part of the patient, also. In this dual identification the doctor strives to retain objectivity in his efforts to improve the mutual adjustment of the patient and the patient's environment. He must be fair to both, although the patient remains his direct and primary concern.

Once he grasps the total situation, by means of the case study, the doctor must consider what can be done to change those features of the environment with which the patient cannot cope and what can be done to change the patient so that he can deal better with this or some other environment. The change to be brought about will, of course, be a chain of events; in the last analysis it must be the patient who changes, and who changes things. But these two goals together constitute the fundamentals of our treatment.

In the actual doing of it, treatment nearly always begins with first aid measures, an attack upon certain symptoms. Life saving and pain saving may require emergency intervention. Thus, the first step in a particular case might be to prevent by special vigilance

an impending suicide; the next, to relieve insomnia or depression by various medications. But the ultimate aim in this case might be to restructure a marital relationship which had become unendurable and to which the patient was reacting as he did. The treatment would endeavor to assist him to attain a more mature attitude toward his wife. It might include some special efforts to get her to be a better wife.

Preliminaries

In planning treatment there are certain preliminary matters upon which the treatment program is contingent. First of all, the physician must decide whether to accept the patient or refer him to a colleague. In the case of referral, of course, there exists a certain obligation to transmit also the referring physician's findings and suggestions.

On the other hand, if the examining physician is to continue his relationship with a patient and conduct or supervise a treatment, he must first decide where and under what circumstances the treatment is to be carried on.

The majority of patients who accept psychiatric treatment are outpatients, receiving their treatment in the form of psychotherapy, pharmacotherapy or other therapies in the course of systematic, repeated visits to the psychiatrist (or psychologist or psychiatric social worker). Certainly if one or several such visits a week will enable the physician to assist in the rehabilitation or reconstitution of the patient, this is preferable to the all-out, 24-hour-a-day treatment by hospitalization or other forms of treatment in selected and controlled environments. Such treatment is more expensive by far and usually has to be supplemented ultimately by outpatient treatment. But for many reasons, total treatment—*i.e.*, treatment in a special milieu—may be necessary.

A part of the preliminary arrangements for treatment relates to the induction of the patient into the treatment. If the patient is accessible, if his attention can be gotten, if he is not too frightened, he must be told in a general way what is proposed so that he can know what to expect and begin to accept it. Most of all he must be made aware of the physician's attitude. Psychiatric

treatment, whether it be psychoanalysis or hospitalization, is likely to be both feared and desired by patients. Much of the patient's fear is based upon misapprehension and misconceptions. To be sure, these fears tend to diminish after a while, even in cases where the patient must be involuntarily detained or confined. But this is to learn the hard way.

Whether hospitalization or outpatient treatment is to be recommended, or even if some other disposal is to be made of the case, the psychiatrist should always remember that while he is making up his mind, the patient and the patient's relatives are anxiously awaiting the "verdict". Both should be relieved of their suspense as soon as possible. (The only exception to this is when complacency is one of the patient's chief symptoms.)

Whether the social worker should first talk with the relatives or the physician with the patient, or whether both actions should be taken simultaneously, depends upon the circumstances of the particular case. Sometimes it is better for the patient to make the first explanation to the relatives; sometimes the reverse.

But it is always desirable that the physician talk with the patient. He should be told a little about the findings—what is wrong and what is not wrong, and what can be done to improve matters. The rationale of the plan need not be given in detail, but the function of the psychiatrist and his associates on the therapeutic team, as well as the responsibility of the patient in the proposed scheme of therapeutic management, should be defined.

Most patients hope for good news and fear bad news. But good news comes in various packages; the doctor may think it should be very good news that he is willing to undertake the case. The patient, on the other hand, may have hoped to hear that no treatment would be necessary.

Naturally, unless he is sadistic, the physician will try to be as encouraging as possible. But he should never make promises that cannot be fulfilled, or intentionally deceive the patient in any way, such as denying the existence of detention, or minimizing various restrictions. Some physicians make the reciprocal error of trying so hard to be scrupulously accurate, verbally and scientifically, that they leave the patient still frightened, uncertain and despairing. It is cowardly for the physician to hedge and qualify his statements

merely to preserve an ideal of impeccable accuracy for narcissistic reasons. If he believes he cannot help the patient, the physician ought to say so, and say so definitely. But if he believes he can help and shares that belief with the patient, a step toward realizing it has already been taken. Nothing in the world is accomplished without optimism, and the fact that optimism may be philosophical or temperamental, and hence not entirely rational, should not disqualify it. The physician himself, in all his wisdom, may not know exactly why he believes he can help the patient and, indeed, may be mistaken.

We ought constantly to remind ourselves that "No man is an island unto himself." Every patient has relatives and friends. They are concerned with his treatment; they are a part of it. They must be dealt with throughout the treatment. In a sense, they will have to undergo treatment of a kind themselves, although we prefer to call it casework. This is an important function, usually performed by the psychiatric social worker, but occasionally it is the responsibility of the physician himself. Furthermore, it is often the relatives who are most concerned with the other matters connected with the initiation of treatment which must be settled before treatment begins. These are the legal and financial arrangements.

Legal Arrangements

There is always an implied legal situation of some delicacy in the treatment of psychiatric patients because there is a presumed possibility of impaired judgment. Sometimes this is not merely a possibility but a well-known certainty which throws doubt upon the patient's competence to make a wise decision regarding his own treatment or management. This is a complicated matter now being reviewed in both legal and psychiatric circles. For after all, a psychiatrist's opinion that a patient can best profit by a treatment which the patient does not want is only one man's opinion against another's.

The circumstances which determine the enforcement of treatment, including confinement, must include some evidence that the patient has a strong propensity to injure himself or others which he may not be able to control. Usually the public will take the psychiatrist's opinion and advice; sometimes the patient will do so without suasion. It is the physician's duty to say what he believes

his patient needs and how imperative or urgent this is. The physician should tell this to someone who has some relationship to and presumably some influence with the patient, and if there is any contest about it, the physician should make this statement in the presence of one of his associates.

Some pages back I remarked that a patient's fear of hospitalization was apt to be largely irrational. But it would be a mistake for the psychiatrist to assume that none of the patient's fear is justified. It is true, for example, that hospitalization will be costly. It is true that the patient's freedom will be somewhat impaired. It is true that there is still a certain stigma attached to psychiatric hospitalization. The patient may exaggerate fear of this and may add various delusions, particularly if he lacks insight regarding the danger that faces him in other directions.

Therefore, while modern psychiatric practice is all in the direction of using outpatient treatment as much as possible and of encouraging voluntary hospital admission wherever possible, some patients will have to be hospitalized against their will. This is why legal procedures, which might be dispensed with in many cases, tend to be a kind of universal requirement. The pressure, however, should be verbal and moral rather than legal and physical. This ideal has to be departed from in some cases; the use of forceful restraint is certainly better than the passive participation in suicide or a crime.

> And here is a good place to emphasize a much misunderstood point. *It is not the physician's duty or even his privilege to make a decision regarding "competence," "insanity," "responsibility" and other such legal abstractions.* No doctor should even permit himself to have an opinion about these matters, since these words do not correspond to our medical vocabulary. It is more than a question of proper words; the conditions mentioned above are legal concepts and adjudications which it is improper for a scientist to assume to be able to define or identify.
>
> Doctors are frequently trapped by a question directed to them—even by judges, in error—as to whether or not a man has the "competence" to stand trial, or to assist his lawyer, or to do business, and so forth. The word competence has a legal meaning which is different from its common speech meaning. Every doctor should look at the two meanings of the word in Webster's dictionary, the ordinary meaning and the legal meaning, and guard himself against misinterpreting the sense in which it is used. A doctor can state what he has found and what he believes to be the logical consequences

in medical and nonlegal terms; it is for the judge or the jury to make legal conclusions.

Similarly, no doctor can "commit" a patient. A doctor may testify that a patient examined by him shows symptoms of mental illness and (in the doctor's opinion) requires hospitalization, even detention in a hospital. It is then up to the judge to decide that such a patient should be "and hereby is" committed to such and such a hospital for treatment. No doctor can declare any patient to be "insane" (or sane!). Making such declarations and designations is the prerogative only of a judge (or jury).

Whatever the arrangements, the understanding arrived at ought to be clearly understood by all concerned. Sometimes only the patient and the physician are concerned, but this is rare. Sometimes an understanding is arrived at between the relatives and the physician without the patient's participation; this again is an undesirable but occasional necessity. In most instances it is well that the understanding be shared by four parties—the patient, his responsible relative, the psychiatrist, and one of his associates.

The young psychiatrist should understand clearly his legal position. He always treats a patient only upon request, the request of the patient himself, the request of the patient's next of kin or best friend, or the state as represented by the committing judge. Only the one who requested the treatment, in most instances, can discharge the physician.

Financial Arrangements

Secondly, among the practical pre-arrangements, there is the matter of economics. Psychiatric treatment is always costly. To what extent the federal government, or the state or the county or a private agency should assume the expense of treating a psychiatric patient is a moot question. Formerly it was assumed that since these cases were hopeless and permanent private financing impossible, it was only the public duty to take on this responsibility. But psychiatric patients are no longer considered incurable, and the rapid development of provisions for such patients in group insurance has brought this matter into sharper focus.

The Yale studies* have shown clearly that the economic and social level of a patient affects his treatment; it even determines the

* Hollingshead, A. B. and Redlich, Frederick: *Social Class and Mental Illness.* New York, Wiley, 1958.

diagnostic designation applied to his illness. This is surely opposed to our best interpretations of scientific method and Hippocratic responsibilities. Many patients could benefit from treatments which they cannot afford. A treatment program that completely impoverishes a family may cause more suffering than it relieves. At the same time, much money is spent ineffectually for the treatment of some patients who might be benefited and even cured by less expensive methods, were it legally feasible to apply them.

Residents in psychiatry will not be much concerned with the financial problems of treatment during residency training. Later, however, in practice in almost any setting, except that of the public hospital, the financial arrangements will become important and often baffling. This includes the physician's fee. No physician feels comfortable about charging more than a patient can afford to pay; indeed, no physician has a right to do so. On the other hand, most physicians cannot afford to pay for the treament of patients who for one reason or another expect such help from the doctor.

Nor is it the physician's duty to help the patient "raise the money." To do so not only "looks bad," but it is apt to harm the patient. It is the doctor's duty to define the financial problem involved in the treatment and to discuss the feasibility of the program he considers ideal, and also the compromises that are possible —such modifications of the program that might enable the patient to afford it.

Where the expense of treatment is borne by someone other than the patient, various complications are prone to develop. Here again, this is only partly the physician's concern. Some of these difficulties can be forestalled if duly anticipated.

The physician has to steel himself both against overcharging and undercharging, the more so because financial protests are so easily borrowed as a basis for resistance to treatment. I recall a patient once who wanted to leave the hospital because—among other things—he felt he was being overcharged. He was paying $15 a day. He employed a lawyer, who advised him to leave the hospital against advice and who obtained a legal writ to permit him to do this. The lawyer's fee was $5,000. The patient bought a car and left town, only to be arrested a week later for having transported a woman over a state line for immoral purposes. This entailed a

further legal expense to him of $25,000. I recall another patient who spread the rumor far and wide that the Menninger Clinic was charging him astronomical fees. He was so angry about this that he ran off to Las Vegas and threw away over ten times the total amount he had paid to the Menninger Clinic! He returned then to us for treatment, asking for a reduced fee "because of financial reverses."

Formulating the Prescription

The preceding pages have dealt with the philosophy of treatment and the steps preliminary to treatment. These include the decision as to whether the patient should be accepted as an outpatient, or as an inpatient and, in either case, where and by whom and under what financial and legal circumstances.

In one sense, these preliminary arrangements are not a part of the prescription of treatment, but in another sense they are the indispensable first steps. They must be decided before other details of the treatment can be planned. Once they have been settled, the program of treatment to be carried on can and must be outlined. The following pages discuss some of the decisions that should be made following the completion of a case study, and included in the section on recommended treatment in the summary of the case study.

Traditionally and logically, perhaps, the various somatic therapies available—medicinal, surgical, dental—might be considered first. Following these we would decide what psychological therapies would be helpful. Decisions in regard to these two general fields of therapy—together with certain recommendations regarding changes in the environment—are sufficient for the majority of patients diagnosed in outpatient departments.

Instead of discussing somatic and psychological treatments first, however, we shall defer them for the following reasons. They are both *partial* treatment in that they occupy but a small part of the patient's day, which is otherwise given to his ordinary life activities. Hospital treatment, on the other hand, is comprehensive treatment twenty-four hours a day, or most of that time. Furthermore, it includes—in many instances—the use of both somatic therapy and psychological therapy. Hence, I shall discuss hospital treatment

first because it is where most psychiatric residents acquire their introduction to psychiatric case study. Later we shall return to the prescription of medicinal, surgical, electrical, psychological and other forms of treatment.

Milieu Therapy

The expression *milieu therapy* is so loosely applied that perhaps we ought to define it. Milieu therapy does not mean a cheerful and encouraging attitude on the part of the personnel, as some doctors sometimes seem to think. The essence of milieu therapy lies in the definite therapeutic structuring of the special environment provided. We have spoken as if this were always a hospital; of course it can be a school, a colony, or even certain kinds of places of legal detention which might categorically be called prisons. The important aspect is not the confinement or restraint, but the structure. This structure involves certain regulations, certain directions, certain control, and in this sense there are certain limitations of freedom with the very purpose of giving a greater freedom in certain other directions. It is characteristic of many patients that they first see the structure as restraining, and later see that same structure as affording a greater freedom.

I do not mean here to skip lightly over the matter of control. The psychiatric hospital or the psychiatric institution of any kind must serve as a protection in two ways. The patient does need protection, and so does the public. If certain patients cannot take the cruel criticisms of the members of the family, they need protection; if they cannot restrain an impulse to dive out a window on to the ground they need protection. If they cannot refrain from drinking too much alcohol or beating their children, or assaulting their friends, these others need the protection as well. But this control cannot be tailor-made for each individual, and hence certain general restrictions will always be necessary. There is no such thing as a completely open hospital. (This is not to decry the idea; the Menninger Sanitarium first developed an open section in 1930.) Nowhere is a patient completely and truly free to come and go. There will still be walls; there are doors to open; there are cautionary nurses and there are doctors who surely do not want their patients to set forth on

suicide. But we try to make the necessary restraint less a thing of physical force and more a thing of concern. A hand-picked human environment has replaced the untutored, unheeding individuals of the patient's ordinary environment, and a part of its function is a continuous surveillance of that patient and the erection of, first, a moral and, only if necessary, a more effective barrier against self-destructive acts by that patient.

Reception of the Patient

To say that an environment is structured in the direction of therapy implies a number of principles which must be understood by the physician before he can prescribe specific features of the treatment. Everyone in a therapeutic milieu has a part in its operation. The entire environment becomes "the therapist". It is the entire hospital setting that does the therapy, and no one person. Indeed, the patients themselves soon become an effective part of the very milieu by which they are healed.

The most important thing, therefore, is that all individuals who live and work together and constitute the operations of the therapeutic machine should be in effective communication with one another. They must be clear in their minds regarding their joint purpose and their joint responsibility. Indeed, the first step in hospital therapy, which it should not be necessary for the psychiatrist to plan or indicate on paper, would be a proper reception of the patient by the nurses and aides and other patients on the ward where the patient is assigned. The patient should be seen immediately by the nurse, introduced to the aides, introduced to some of the other patients. This will be a reassuring symbol of the friendliness and good will of the institution.

An explanation of all the rules, regulations, privileges and possibilities of the hospital should certainly be deferred for a few hours or a few days. Plenty of new sights and sounds are reaching the patient's eyes and ears without his having to be confused by a lot of instructions regarding curfew hour, cash withdrawal and passes. It is enough if he is told on the first day who some of the people about him are, and where the toilet is.

The patient will be visited shortly after his admission to the hospital ward by the psychiatrist himself. If the patient has already

been examined, this will re-establish the contact begun outside the hospital. If the patient has been admitted to the hospital on an emergency basis, the examinations are yet to come and will of themselves constitute a very important part of the treatment. Not all of the patient's time nor all of the physician's time will be taken up in the examinations, and the spare time of the patient during this period requires careful planning and cushioning. There ought to be a minimum of long, weary, anxious, painful hours (for the patient) relieved only by his anticipation of the physician's return. The complete treatment program may have to be introduced in parts and pieces, tentatively, as fast as definite indications are detected. Naturally, like all treatment programs, it will be subject to revision in the light of further knowledge.

Prescribing the Attitudes of the Milieu Personnel

The attitudes we ordinarily have toward other individuals or toward events or certain kinds of behavior are determined by a long personal history in conjunction with a long ancestral history. These attitudes are usually taken for granted as fixed, characteristic, logical and not made to order.

Yet in a psychiatric hospital we find it necessary to manifest attitudes toward patients not based on our likes and dislikes, preferences or prejudices, or even upon our common sense, but rather upon certain scientific principles. Indeed, from the standpoint of the general public our attitude toward the mentally ill is not one of common sense revulsion like theirs. It is a strange, bizarre and, some people think, morbid attitude of interest in the unpleasant, the disagreeable, the perverse.

To us in psychiatric work, the attitudes of those who care for our patients assume a quality of classic beauty. They minister patience and kindness to individuals who are sometimes highly provoking, offensive, dangerous and, according to ordinary tastes, disgusting. One should remember that just because of these unlovely qualities, it was formerly the accepted practice for the wretches hired or compelled to care for such patients to beat, kick, curse, starve, freeze, and neglect them. Today, with the goal of understanding their behavior, we have substituted tolerance, helpfulness, gentleness and care in a nonretaliatory spirit.

There are still hospitals where the attitude of the personnel is one of discouragement, indifference and even contempt. But we are assuming something better than that, and something better evolves whenever and wherever all workers with the patient are made to feel their contributory responsibility and importance. If the morale and team organization are what they should be, nurses will speak highly of aides, aides will speak proudly of physicians, physicians will commend therapists, and so forth.

The trained personnel of the modern psychiatric hospital recognize the dangers and opportunities of hospitalization. On the dangerous side they know about over-attachment and countertransference. They know the danger of over-trusting the alcoholic patients. They know the danger of elopement, of suicidal attempts, of sexual activities, of bribery by patients or relatives, of concealed medicines and sharp instruments, of access to alcohol and drugs.

Hence, for all their kindness and tolerance, the hospital workers must know when to be firm, when even to be severe. They must know, too, which patients not to sympathize with too much and which patients need more than the average evidence that we love them. Our attitudes by no means include the condoning of many acts nor unnecessary indulgence nor undeserved praise, but they do mean that we cooperate in developing the attitudes most likely to assist the patient in correcting his own improper attitudes. We therefore try to be, above all things, consistent.

Many years ago, in the hospital which later became the C. F. Menninger Memorial Hospital, we began the practice of indicating in detail in each case what attitudes the nurses and aides should take toward various moves made by the patient. Doctor Will Menninger and his associates worked this out in much detail and a "Guide to the Order Sheet" was prepared describing ways in which nurses and aides might cope with patients helpfully. It is not always possible to prescribe specific attitudes, but the following excerpt from the "Guide" will illustrate the idea.

A. Responses to patients' protests regarding restrictions:
   1. Patiently explain as many times as necessary
   2. Listen attentively with sympathetic comment
   3. Promise to refer to the physician
   4. Divert attention

5. Emphasize the importance of restriction and the value of compliance
6. Listen without comment

B. Various ways in which to solicit patients' cooperation:
   1. Making no demands but awaiting spontaneous initiative
   2. Expressing a motherly concern
   3. Rewarding by notice, praise, visitation
   4. Implying the doctor's approval or pleasure
   5. Invoking the concern of loved ones
   6. Presenting the matter as a privilege or an indication of growth
   7. Expressing disappointment at patient's refusal
   8. Humorous approaches
   9. Matter of fact approach
   10. Announcement as if refusal were unexpected
   11. Persistent urging, coaxing, persuading
   12. Firm insistence
   13. Show of force

C. Ways of answering requests from patients which cannot be immediately granted:
   1. Explain reasons for denial or deferral
   2. Promise to investigate possibility
   3. Listen with minimal comment
   4. Attempt to divert attention
   5. Substitute other activity or interest
   6. Refer patient to physician
   7. Refuse firmly with little explanation

An attitude of friendliness would seem an obvious indication, but the ways of manifesting friendliness of the most helpful kind may vary considerably. It may require considerable effort, persuasion, carefully expressed concern, or more than average attention on the part of the nurse and the physician. Some patients thrive on praise, while others are injured by it. Some patients regard it as the height of friendliness if anyone is willing to sit down beside them quietly, whereas other patients would regard this as an aggressive intrusion.

For some patients the most important attitude is one which might be described as "watchfulness without suspicion". Some patients surreptitiously plot their destructive and self-destructive maneuvers and, of course, seek to avoid detection. Other patients require less the encouragement of the personnel than the deterrence. Behind the friendliness of the nurses and aides and doctors there must always be a definite firmness with reference to certain immutable necessities.

In general one could say that there are those patients who cannot see or cannot accept opportunities for pleasure, and those who tend to abuse, exploit, hurt and destroy their opportunities. The former require encouragement, the latter restraint. Both need direction or re-direction. The techniques of accomplishing this encouragement, restraint, or direction, are sometimes quite obvious to the nurse or aide; in other instances it is helpful if such techniques are specifically prescribed. For some patients, it is essential that we show sympathy and concern beyond what the ordinary individual would expect or even appreciate. With other patients, it is wise to avoid lending an ear to bids for sympathy and to be pleased rather with efforts at self-help made by the patient. Some patients require great watchfulness; others do better if seemingly ignored. Some patients need cautionary reminders frequently, like little children; others do better if they are treated as if they were more adult than they actually are.

The examiner's impressions in regard to the most useful attitudes for the nurses and aides to take toward a patient are especially valuable in the beginning of treatment. Subsequent observations made by nurses and physicians may lead to a change in this prescription; indeed, to many changes. This may be one of the clearest criteria of the patient's improvement.

Functions of Psychiatric Nurses

Although physicians and others are not excluded, much of what has just been suggested pertains to the attitudes of the nurses and aides. Nurses and psychiatric aides are, of course, the persons with whom the patients in a hospital have the most continuous contact. Theoretically, the aides assist the nurse in performing nursing duties. This is simple to arrange when the primary duties of a nurse are conceived to be bedside care, the dispensing of medicines, the finding of bathrobes and other such personal attentions. In modern psychiatric nursing, none of these functions are very important. The patients often make their own beds, eat their meals in the dining room, and have no need for bedside service. Nursing care becomes rather a matter of the supervision and facilitation of a new living pattern. Gradually the work of the psychiatric nurse has come to be more and more administrative and supervisory. This is not necessarily to her liking, because it leaves the psychiatric aide as the

person closest to the patient—his guide, his protector, his mentor, his companion, his friend. But the competent nurse will help in this, although it is of the utmost importance in good milieu treatment to have aides of a calibre, training and dedication which permit them to appreciate and develop the opportunity to be helpful.

A psychiatric nurse has many responsibilities in addition to ward management. Upon her fall the important though seemingly petty duties of limiting the personal possessions retained by the patient; noting unusual habits such as long absences, prolonged stays in the toilets or showers, surreptitious activities of various kinds, developing feuds between patients. This is not to imply that the nurse watches only for ominous signs; she represents the eyes and the ears of the doctor when he is off the ward. She must be alert to indications of improvement or the reverse in whatever form they are manifested.

In some instances special nursing will be required—for example, for patients who are continuously impelled to make self-destructive or run-away attempts. This is supervised by the head nurse, and her attention and that of the aides should always be called to the special precautions required in certain cases. Even for patients who require no extra nursing care, the prescription must give directions as to the amount and kind of supervision necessary for the patient, always making the reasons clear.

For example, a prescription might read:

"This patient is capable of entering into the general ward program, assuming responsibility for his own dressing and grooming, and taking his meals with other patients in the ward dining room. Although he is active and oriented, a grounds pass is contraindicated because he feels dissatisfied to remain in the hospital and would be likely to leave if he goes unaccompanied from the ward. He is tractable to immediate suggestions from staff members, though, and may go out of the ward for short periods with a nurse or aide either singly or with groups of three or four patients."

Or, again:

"Because of the patient's disorientation, memory defect, and restlessness he requires close nursing supervision including help with dressing, accompaniment to and from meals, and assistance in going to the toilet. As long as the above symptomatology continues, he should not go off the ward except for necessary electroencephalographic tracings and X-rays, and then only with the attendance of a nurse or aide."

Or:

"The patient's physical condition makes bed care necessary for at least the next several weeks. Though unable to speak, he is relatively alert mentally, considering his recent cerebral hemorrhage. The patient's relatives live several hundred miles from the hospital and they will be unlikely to visit the patient. Therefore, in addition to the nursing care necessary for a bedfast patient, this man will benefit by friendly visits from nurses and aides."

There are six principal emergency situations, the greater-than-average likelihood of which should be communicated to the nurses and all others who are associated with the patient. These are impulses toward self-destruction or self-mutilation, impulses toward assaultive behavior, elopement propensities, loss of consciousness (especially those with convulsive or dissociative phenomena) fire-setting propensities, and various medical conditions involving sudden disability—cardiac, diabetic or uremic crises. The physician will clearly indicate any known likelihood for the occurrence of any of these events and in some cases suggest precautions beyond those standard in every psychiatric hospital. For example:

"N. B.: *Fire-setting propensities!*

"This patient has repeatedly set fires within doors, always surreptitiously. He is especially adept at secreting matches—occasionally lighters—on his person. Visits from relatives should be carefully arranged, and followed up by searches. He must not be permitted to smoke or leave the hospital except when individually accompanied, and should not be assigned to any work or recreation bringing him near to the kitchen, shops where fire is used, or workmen from whom he might solicit matches."

Contacts with Other Patients*

It is not generally appreciated how much therapeutic effect the patients in a treatment milieu have upon one another. The relatives

* There were long arguments among us as to whether the word *contacts* or the word *relations* should be used here and elsewhere to indicate some mutual interchange between the patient and those about him. It is true that the word *contacts* is used in business and everyday life by many non-psychiatrists, but this should not invalidate it for our use if the meaning is clear. The fact that some people use the word improperly as a verb is deplorable but not relevant. On the other hand *relations* which is widely current is very apt to acquire mystical meanings especially when it is lengthened into *relationships* and then on into *inter-relationships*. To be less pretentious, and we think more clear, we have fallen back on the simple, common speech word *contacts*.

frequently deplore the fact that their loved one is obliged to associate with "those other patients", and remarks are heard to the effect that "If I had to be around people like that all day, I'd go crazy myself". Similar thoughts occur to many residents in the early days of their training.

A definite prescription should be attempted regarding a patient's contacts and associations. It is true that some patients are *very* disturbing to some other patients—as well as to the staff members—and it is very important, especially during the first days or weeks of hospitalization, that such contacts be prevented. As a new patient gradually becomes acquainted with those about him, however, he tends to make more and more allowances for their behavior, appreciating that they make allowances for his. This will be more characteristic of some patients than of others.

Friendships are valuable, though they usually cannot be prescribed, but tend to develop automatically. Sometimes they become too intense, and this must be guarded against. Such a likelihood may be predictable from the case study, and if so, instructions should be given to the nurse about this. Again, the case study may have indicated to what extent the patient needs or shuns peer approval, and how much peer criticism he can take. The latter is never so painful as criticism by those whose judgment seems to be better—relatives, friends and other outsiders.

The interaction of the patient with other patients, the increasing tolerance for one another, the development of cooperative efforts in group activities of various kinds—all this is a part of the hospital life, the new program of environmental interaction. Some patients are capable of beginning with much socialization and going to more; others must be guarded against the panic that comes from too great a threat or opportunity of this kind too early. Some patients do best to have only the nurse companion for a time, then develop gradually through entering a small group—perhaps in a checker game, or three women sewing together, then on to larger groups in concerts or classes, and later more active groups of workers or players. A general program for this may be automatic, but special emphases or precautions or trials should be indicated in the prescription.

Living and Learning Program

It has been discovered, forgotten and rediscovered many times in the history of psychiatry that various kinds of structure and prescribed activities with the proper kind of supervision have a therapeutic effect. Long before there was a consistent theory of personality or personality disorder, intuitive hospital superintendents or private clinicians discovered that some patients could be helped to overcome their inhibitions or their ignorance or their initial lack of skill in various directions and gradually acquire means for great satisfaction to themselves in creative activity, in recreational activity, or in plain, simple useful work. And in these greater life satisfactions lay health.

Thus there arose at various times and with sporadic and fluctuating support all kinds of "therapies"—physical therapy, occupational therapy, recreational therapy, musical therapy, drama therapy, educational therapy, and so forth and so forth. What all of these come to, in theory, can be put something like this:

Human drives must be directed away from their primary objectives of destruction and self-aggrandizement. In the healthy-minded individual, they have been automatically channeled according to certain patterns of training and of living experience. These patterns tend to persist with minor changes to fit changing situations, but the capacity for learning new methods, even though not much used, is not lost.

In the mentally ill, however, there have frequently been a serious disruption of the patterns and an apparent paralysis of the capacity to acquire new patterns. The instinctual drives seem to be most inexpediently directed, to the exclusion of all the healthy-minded ways of living.

Our psychoanalytic theory of personality function assumes that much aggressive drive is absorbed in activity directed toward work and toward play. A psychological process called neutralization or sublimation occurs, so that the activity thus expressed, although stemming from aggressive sources and intentions, is not accompanied by hostile feelings.

Still more highly sublimated aggressive energies appear in creative work such as painting, music, study, writing. These activi-

ties are accompanied by many emotional values. In some there is a considerable degree of narcissistic satisfaction. In others the greatest satisfaction seems to come from the mutuality and interaction of the group activity or, again, from the commendation of the instructor. In still other instances the activity is most appreciated as a means for the physical expression of emotions that cannot be verbalized—sometimes aggressive, sometimes depressive and guilt-laden.

Formerly the emphasis in the prescription of activities was placed either upon the modality (ceramics, volleyball and so forth) or upon certain psychological reactions which we attempted to predict and exploit. The importance of the therapist as a friendly counselor and understanding supervisor was emphasized.

In recent years there has been a radical change in our concept of the whole field formerly described as adjunctive therapy. It seems better rather to conceive of all such activities as forms and modalities of living structured in a didactic program. These are just the things that human beings *do* in life other than eat and sleep—*all* human beings, not just sick people. It may be that sick people need to learn again or to learn better or to learn more such methods. They are what men live by. Patients, like others, *need* them. Patients need them even more than well people, at least for a time. In the retreat from a painful aspect of the life situation into the protected milieu of hospitalization, there is frequently a tendency to relinquish the very things the patient needs *more*, not less. Along with the surrender of business or family responsibilities and problems which he could not solve, the patient often gives up the *satisfactions* of the work he was doing, with nothing to take their place.

We conceive of this area, therefore, in terms of an educational program, a school in "practice living". Those who were formerly designated "therapists" (as if no one else in the hospital were giving therapy) have risen, in our concept, to the role of teachers. They teach ways of living, better ways of living, civilized techniques of expressing instinctual urges. Like all teachers, their personalities and examples are important. But more important are their special knowledge, their skills, and their example in knowing and using and loving certain techniques of dealing with the realities and opportunities of life.

Time Scheduling the Daily Program

The hospital is a little world in itself, by definition. Most of the reality requirements of the outside world still hold—time, gravity, metabolism and the like. Meal hours and sleep hours are about the same. But the eight-hour work day and many of the rules of social intercourse are not quite the same as outside. Work is not paid for; play is not a luxury. There are, rather, certain arrangements in space and time for assigned *work*, assigned *play*, assigned *study*, and assigned efforts at *creative activity*.

A few hours each day will undoubtedly be required for rest, reflection and various personal attentions, but most of the day will be structured. The examining physician may or may not be able to decide which particular form of recreation or which creative activity is best. But if he assumes that approximately two hours of each day should be allotted to each of the four areas mentioned, he can indicate which of these he feels might be stressed or which of them, for some reasons known to him, might be slighted. He will know and should indicate whether these lessons in living, in working and play and learning, can best be carried out alone or with small groups or with larger groups. These are not electives; they are assignments. They are prescribed.

Naturally, if there are special dangers likely to occur in the course of activity assignments, the doctor will give warning of these. If his patient has a cardiac lesion, vigorous physical exercise will be enjoined. He will know how much competitiveness should be emphasized or suppressed, how much cooperative effort can be expected, what difficulties there may be in arousing or directing interest. All of this he can suggest in his prescription and in the referral note to those in charge of the living-learning program.

Continuing Contacts with the Outside World

When a patient enters a special milieu like a hospital, with more or less retreat from the outside world, his relationships with many love objects (and hate objects) are interrupted or attenuated. From seeing or hearing from certain persons every day, the patient is in a situation where he may neither see nor hear from them for many days. After the wrench of parting, and sometimes even the welcome escape from certain unpleasant relationships, the patient

finds himself surrounded by other human beings with new possibilities in the way of love and hate objects. The old ones are missed. True, we hope in each instance that the separation will be brief. But there are always uncertainties about this. Both the patient and those who love him have conflictual feelings; they both wonder sadly, sometimes even frantically, if they will not be forgotten. I once worked in a psychiatric hospital, the superintendent of which believed it kind and, indeed, imperative, to tell relatives that they should go home and forget their loved one, the patient. "He will probably never get well, or at least so you had better expect," he would say. "Go home and make your lives over as if he were dead. Don't keep hoping for the impossible. He will soon forget you if you can just forget him and let him alone."

Today this sounds incredibly cruel and unwarranted. It is true that while the patient is living in the hospital milieu, the people about him will be for a time his most important attachments. With them he will be living, working and playing; aides, nurses, doctors, teachers and fellow patients will provide transitional friendships serving to sustain him during a trouble period. Some of these will be relinquished when he is able to return to his home; some of them will be permanent. During the hospital period, relationships with people outside the milieu will necessarily be diminished, but should not be severed or impaired. Some patients suffer acutely from the feeling that they have been forgotten or that they are not needed or wanted.

That this should be a carefully regulated program, however, is most essential. It is true that these people have hurt this patient and that this patient has hurt his people. Distance has been established between them for a purpose; it should not be immediately eliminated. But in this day and age we expect letters from even those far away, the frequency of which will depend upon our intimacy and concern. Letters to and from patients are usually censored, to use an ugly word, by a physician who makes certain that no poison of misunderstanding can inadvertently or surreptitiously creep in. Letters to the patient are encouraged; letters from the patient are encouraged. And as soon as he is ready for it, the patient will receive visits from the letter writers—brief at first and infrequent, later frequent and for longer periods.

All this should be a graduated and progressive program. The initial recommendations (prescription) will have to do with the schedule for the immediate future, with some indication of the rate and speed with which it can be expanded. Sometimes it is better for patients to have no visits for a period, and there are always certain visitors whom the patient should not be afflicted with.

A word should be said here about telephone calls. Some people for reasons of illiteracy, laziness, or anxiety apparently cannot really maintain a personal relationship by correspondence. They must hear the human voice if they cannot see the human figure. The ubiquity of the telephone and the everyday nature of telephone calls makes this a big problem for the psychiatric hospital. For telephone calls cannot be overheard. Intense anxiety or rage can be stirred up by them. Much false information can be transmitted by them. For this and other reasons they are much frowned upon in most psychiatric hospitals. This has to be explained to relatives and to patients. In spite of it there will be occasions when permission for a telephone call under supervised conditions should be granted. If the patient is one for whom this sort of special arrangement has to be made, it may well be included in the prescription.

A further aspect of the program of continuing contacts with the outside world has to do with "passes" and "trial visits." Actually these are two different things. Trial visits are usually made to the home, while passes are for such things as shopping trips, theatre, short excursions, overnight stays with friends or visiting spouse, and so forth. As a general thing, my experience is that these experiments are pushed upon the patient too rapidly by young psychiatrists, who speak of them as "privileges." This is surely a paradoxical use of the word; it is the patient's chief *privilege* to be in the hospital, not out of it. The program of treatment is his great privilege—not the quitting of it. To be sure, we know what is meant here; we all like a vacation, and children appreciate their Saturdays away from school. It is, indeed, good for a patient to have an entire change of scene for a few hours. But the young psychiatrist is inclined to see this in terms of his own fantasies, and misinterpret the meaning of the patient's petition. Patients who beg to have such a change, to be allowed to go downtown, for example, are likely to have something else in mind which the naïveté of the psychiatrist

does not suspect. The most satisfactory clinical program is usually one in which there are few passes until shortly before the patient is discharged. Trial-and-error experiments must be made, but they should be made with great caution to test or stretch the patient's capacity and *not* to reward him, bribe him, gain his good will or surrender to his importunities.

Regular Contacts of the Physician and Patient

The success of milieu treatment depends in part upon the skill with which it is organized and administered, in part upon the way in which it is prescribed and followed up. In the program of total hospital treatment which has been outlined here, the patient's personal physician assumes a key role. It is he who interprets this temporary therapeutic world to the patient; it is he who introduces the patient to it, directs his participation in it and observes his adjustments to it.

The physician is the entrepreneur of the process. Having stipulated the way in which the patient is to be received into the general control measures of the milieu, and prescribed the attitudes and techniques to be used by the personnel toward the patient, the doctor will be concerned to see how the program goes. He will want to know how it goes from the standpoint of the patient. He is equally concerned with learning how it goes as seen by the nurses, the aides and the teachers.

From such observations he will be able to make indicated changes in the treatment program. He will also be able to fill in and modify at various points the diagnostic case study, for he will have learned more about his patient. He will be making notes on the trend of the disorganization process and charting it. (See next chapter.)

The patient will be fully aware of the fact that the physician is in charge of the program. He will know, too, of the physician's relation to the outside world, even though this may be mediated through the social worker. The patient will expect to see his physician often, for no program can run itself, and the patient more than the healthy-minded person needs to be reminded of his obligations and assignments. Physicians, being human, sometimes shift from a professional therapeutic position to a more characteristic

paternal or maternal one. They excuse patients from tasks or appointments or overlook infractions of important rules or condone unhealthy tendencies which the patient could control, such as overeating, oversmoking, slovenly dressing, ill-mannered demeanor and the like. The therapeutic attitude that the physician should have at all times is this: I am concerned with your problems, your distress, your impaired capacity for living, your unsuccessfulness. I see all this as your illness, something from which you hope to emerge. I am here to encourage that hope, to implement your wish to get well and to help you take advantage of this situation as a means of doing so. I have outlined a program for that objective and I am always glad to talk with you about your efforts to follow this program.

The patient will frequently attempt to force the physician into a more specifically therapeutic role: "I don't like these activities," he will say. "I would rather just talk to you." This is flattering but it is apt to be deceptive. No physician will rebuff a patient's attempt to verbalize his pain and bafflement, but a hospital physician does not have the time which a thorough ventilation of these matters usually requires. If the patient has a strong urge in this direction, psychotherapy is an additional modality which may be used. This may be during the milieu treatment, but usually it begins after a point has been reached where a less structured, less controlled environment can be arranged for. There are some patients who will not be able to leave the hospital until they have had some psychotherapy. The hospital physician as a psychiatrist is concerned with the psychopathology of his patient and will not discard any opportunity to understand him better; but he should not consider himself primarily responsible for furthering a process of running interpretation or continuous exhortation.

The physician cannot always indicate just how much time he will spend with a patient. He may find fifteen minutes twice a week enough, or he may find thirty minutes a day not enough. In the latter case, of course, something further must be arranged. But here we are speaking of the prescription; in formulating the prescription of total treatment the physician should estimate what he expects to be necessary in frequency and length of personal contacts with the patient.

The physician has a further role in connection with physical and chemical treatments, some of which he not only prescribes but carries out, in contrast to psychotherapy, which he may prescribe but usually does not perform. We proceed now to a discussion of these.

Somatic Therapy

Under the head of somatic and other empirical therapies one thinks of the medicinal, physical, dental and dietary measures which have been found through long experience or recent research to be useful in psychiatric conditions. To these let us add electroshock and insulin shock, which owe their effects to obscure processes so unclear in nature as to justify a separate classification.

One or several of these methods of treatment may be all a particular patient who has been studied seems to need. With the aid of a sedative, an anti-convulsant or an occasional "prophylactic" electroshock treatment, a patient may be able to maintain himself in outpatient status indefinitely, or he may be discharged from treatment entirely. With or without somatic therapies of various kinds, some patients receive only psychotherapy. Even hospitalization does not preclude somatic therapy and psychotherapy; indeed, most hospitalized patients receive one or both of these in addition to rather than as a special feature of the therapeutic milieu.

Medicinal therapy includes all of those indications for pharmacologic assistance to the somatic processes which have become the body of knowledge of internal medicine in the course of its development. The psychiatrist prescribes such medicines as the patient's condition requires, on the basis of his knowledge and his findings from the patient's physical examination. In addition the psychiatrist will consider sedative, ataractic and hypnotic drugs and prescribe those which he prefers as indicated according to a schedule which will afford maximum relief with minimum habituation.

In prescribing the medicinal therapy to be given a patient, the dosage and the frequency and avenue of administration are essential. In the interests of thoroughness, it would be wise to indicate in the record or on the schedule of treatment the purpose for which the medication is recommended. For example:

Chlorpromazine 50 mg. p.o., t.i.d. for the persistent restlessness. Hours: 8 a.m., 1 p.m., 7 p.m.

In a teaching program a prescriber presenting the material to a senior staff psychiatrist or a consultant would be expected to specify or amplify his thinking (not his record) still further. For example:

"Since admission to the ward seven days ago this patient has been preoccupied with delusions of paranoid content. She is restless, and she sleeps and eats poorly. The symptoms interfere with her entering into the ward program and with her participation in other forms of treatment.

"Because she is a small woman weighing approximately one hundred pounds, 150 mg. chlorpromazine represents a moderate beginning total daily dosage. As long as no premonitory signs of serious side effects such as agranulocytosis or liver damage appear, the chlorpromazine dosage will be increased at weekly intervals by 50 to 100 mg. daily either until a dosage of 500 mg. daily is reached, or until the restlessness and preoccupation subside.

"The chlorpromazine is likely to alleviate the present acute restlessness and make possible the patient's participation in some of the rehabilitation and socialization programs prescribed for her. After the expected improvement occurs, the chlorpromazine will gradually be withdrawn."

Physical therapies, so-called, include the use of heat, light, massage, baths, packs and exercises. They are indicated in the case of more or less obvious physical disabilities. Some of them may also serve a sedative or stimulating function. Whatever is prescribed should be definitely stated. For example:

Posture exercise class for 20 minute sessions 3 times weekly. Suspend in case the patient suffers a convulsion within 2 hours prior to the class.

Dental treatment: While we no longer subscribe to the fantasy of dental infection as the cause of mental illness, the importance of proper dental hygiene, dental therapy, proper occlusion and other special concerns of our dental colleagues are better recognized than ever. Complete assessment of a patient's general physical status always includes dental examination by one proficient in making it and should be followed as promptly as possible by whatever treatment the dentist recommends. If this involves extensive repairs, extractions, orthodontia or dental reconstructions, plans should be

discussed with the patient and his family as soon as possible and always before the work proceeds. Outpatients will generally make their own arrangements for dental treatment; in the hospital the patient's physician makes them.

Dietary regulation: Patients receiving psychiatric treatment are not immune to physical ailments that require dietary measures; for example, conditions such as diabetes, hypertension or duodenal ulcer. Dietary irregularities often accompany a disorganization, resulting in nutritional disturbances like vitamin deficiencies, general malnutrition or obesity. Therefore the type of diet must be stated: regular, high caloric, high vitamin, special diabetic, etc.

The patient's symptoms or his attitudes may determine where he eats his meals and under what circumstances. Outpatients under psychiatric treatment sometimes become careless or at least irregular in their eating habits, and may require either cautioning or strict injunction. Some, of course, eat too much; others too little.

In a school or hospital there is usually a general diet which is carefully selected, but from this there will be many reasons for making departures in special cases. A patient's shyness or helplessness may preclude his eating in the dining room with other patients, so tray service is desirable if not imperative. Other patients, even when given the example of their fellow patients, will tend to gorge themselves or starve themselves. Some patients will eat only if spoon-fed by nurses or aides; a few must be tube-fed because of their continued disability or disinclination to eat. It is important that the nurses or others who supervise the meals know which patients to encourage, which to ignore and which to insist that they eat. These are a part of the routine achievements of nursing care, but any special measures should be specified by the physician in the prescription of treatment.

Shock therapies: Before the present flood of popular ataractic, sedative and anti-depressant drugs, psychiatrists used many empirical therapies more or less extensively, some of which have fallen into disuse. Among the latter are insulin shock therapy, carbon dioxide inhalation treatment, metrazol convulsive treatment, electronarcosis, narcotherapy, and psychosurgery. Earlier fever treatment for neurosyphilis had already given way to the more effective and less hazardous antibiotic treatment.

One empirical form of therapy retains a place among the generally accepted and, as yet, irreplaceable treatment measures. Electroconvulsive therapy usually can interrupt a serious depression, give the patient relief from his distressing moods and self-accusatory ruminations, make him more accessible to rehabilitative forms of treatment and, most important of all, diminish the suicidal risk that goes with severe depression.

A psychiatrist who orders electroconvulsive treatment as a part of the program for one of his patients can assume that the team that administers the treatments will carry out each individual treatment in the accepted manner. The psychiatrist probably will consult with the doctor who gives the treatments, but the psychiatrist in charge of the patient plans the over-all management of the convulsive therapy, including the frequency of treatments. He must explain the treatment to the patient and the patient's relatives, and he should obtain their consent to give it. The psychiatrist arranges for the necessary additional preliminary examinations such as X-ray of the spine and sometimes electrocardiographic and electroencephalographic tracings. He orders the withholding of food and fluids before the treatment and designates the medications to be given in conjunction with treatment.

An order for these might read something like this:

Begin course of electroconvulsive therapy starting with three treatments the first week. Schedule the first treatment January 3, 1960. Give atropine gr. 1/75 hypodermically half hour prior to treatment; following convulsion, in which the patient is maintained in tonic phase, a non-convulsive current will be applied, at which time the patient receives Coramine, 1½ cc. intramuscularly if indicated.

In his discussion of the above prescription with a consultant or other colleague, a psychiatric resident might verbally explain it as follows:

"The patient, age 48 years, showed clinical symptoms of depression for the first time one month ago. She has lost 25 pounds weight; eats poorly; has been constipated; thinks and moves slowly; feels hopeless; ruminates about her own unworthiness; and expresses suicidal thoughts. She feels worse in the morning than in the evening. The patient's response to the treatments will determine the length of the course of treatments, but probably she will receive

three treatments the second week, two each week for the next three weeks, and one each week thereafter until she has taken approximately 20 treatments. As soon as her general condition permits, the other forms of treatment to be described will be started. These include psychotherapy and adjunctive therapy."

Psychological Therapy

In the minds of many psychiatrists psychological therapy is the mainstay of the psychiatric armamentarium. This appraisal is generous; it is, perhaps, a reaction to the overemphasis placed by some colleagues on the value of somatic therapies. But such childish pitting of one method of treatment against another has no place in science. All therapies must be used, if and where indicated, and in a balanced program. It is true that since some patients receive little or no somatic therapy, psychological therapy is probably the most widely used of the three main forms of therapeutic approach, but thousands of patients recover annually with *no* formal psychological therapy.

Formerly psychotherapy was used only with outpatients. In fact, it was regarded as a kind of substitute for milieu treatment, *i.e.*, for hospitalization. This statement will shock many colleagues, but the fact is that this is just about how psychotherapy was formerly seen and used, particularly by the neurologists. The idea was, so to speak, to "talk the patient out of it". If the doctor was unsuccessful in this effort, the patient might have to be hospitalized—and the patient was often reminded of this fact. The one hour a day with the psychotherapist might have to be replaced by 24 hours a day in the hospital.

Once in the hospital the patient was supposed to get well, if at all, as a result of rest and isolation and the special merits of the changed milieu, including its confinement benefits. As a rule any efforts to change a patient's point of view were left to the nurses or others who had time to spend listening to the patient's talk.

With the introduction of psychoanalysis it might seem as if the application of psychotherapy to a hospitalized patient were put further off than ever, but it was Ernst Simmel who pointed out that there were other implications about treatment by psychoanalysis than the couch and friendly association. He pointed out that psychoanalytic principles could be made valuable by use in the admin-

istration of the hospital and the programming of the patient's day. His work along these lines in Germany was introduced in this country by us and several others. We also used psychoanalytic treatment for some hospitalized patients.*

Longer experience revealed a number of special difficulties. One of these was the expense of providing both milieu treatment and psychotherapy for the same patient. Another was the tendency for these two forms of treatment to compete with each other, to tend to cancel out some of the benefits of both. Some colleagues in other places have not been deterred by this, but feel that every hospitalized patient should have systematic daily special psychotherapy. Where this is done, the psychotherapist is not in charge of the patient, who remains the special concern of the hospital physician.

In order to prescribe psychological therapy the physician should have clearly in mind what he means and what he wants understood by psychological therapy or "psychotherapy." Many pages in books and journals discuss the essence of psychotherapy, but a generally-agreed-upon definition does not exist. For practical purposes, let us define psychological therapy as comprising efforts made by one or more individuals to further a beneficial change in a particular individual by modalities not physical or chemical, but depending essentially upon an interchange of communication. This is an awkward way of putting what it is simpler to call "talking therapy", though this is not quite accurate because nearly everyone agrees that more happens in psychotherapy than merely the exchange of words.

The hospital physician will undoubtedly make some effort at counseling, suggesting, explaining, exhorting, reassuring, disapproving—to change the patient or induce the patient to bring about some change within himself. But this will in a sense be incidental to his milieu treatment supervision.

When some kind of special psychological treatment seems indicated beyond this important and essential but minimal effort of the hospital physician, it must be prescribed and arranged for with other parties.

* I remember discussing this with Professor Freud, who admitted that he had never tried it nor felt very optimistic about it.

For practical purposes there are four general types of psychological therapy:

1. Formal psychotherapy, meaning repeated interviews vis-à-vis with a psychotherapist, usually in the latter's office, at regular intervals. The technique used may be psychoanalysis, psychotherapy, non-psychoanalytic psychotherapy, hypnosis or other methods.
2. Formal counseling, usually with an adjective designating a particular field, such as religious, educational, vocational, industrial.
3. Group discussions and explorations under the leadership of a trained individual, either group psychotherapy, group discussion, psychodrama or other forms.
4. Various devices making use of the companion, sponsor or "big brother" concept.

Formal psychotherapy: This *Manual* is not the place in which to develop in full the theory and practice of psychotherapy. The essential principle of it is that a therapist listens to a patient and endeavors to understand what the patient is trying to communicate about himself, responding to this in such a way as to enable the patient to understand himself a little better and communicate a little more accurately what he finds difficult about life. Again the therapist responds in such a way as to further the process of clarification. Gradually the process of redirection and reorientation takes place.

Formal psychotherapy is of two general sorts. These go by various names which are only approximately and roughly synonymous: Expressive, deep or exploratory psychotherapy and suppressive, supportive or hortatory psychotherapy. Essentially these differ in the same way that poulticing an abscess differs from incising it, or that corrective orthopedics differs from operative orthopedics. Some sleeping dogs are better left to lie; others are better stirred up. Some scars can be removed by surgical excision; others had better be left alone rather than replaced by larger ones. Figures of this kind give some implication as to the different approaches or techniques of psychotherapy.

In general, it is my opinion that too much reliance is apt to be placed by psychiatrists on formal psychotherapy. It has so much power in certain cases that the young physician is apt to be tempted to apply it to all sorts of cases rather indiscriminately. Severe cases of mental illness are best treated by milieu therapy with a minimum

reliance upon psychotherapy unless it is given very intensively by very skilled and experienced psychotherapists. Psychoanalysis in its standard form is not applicable to highly disorganized cases and is not necessary in mild illnesses. Many types of psychotherapy which are less extensive and less expensive can be helpful in illnesses of moderate severity and of relatively short duration.

A decision as to exactly which kind of psychotherapy is to be used is not always up to the examining physician. If he believes vis-à-vis interviews with a psychotherapist might accelerate the recovery process he should recommend it. If his information is complete enough, he may indicate what he thinks might be accomplished by psychotherapy, what kind of psychotherapy is indicated. He may even go further and indicate—with reasons—whether he believes a female therapist or a male to be preferable. Even more important is his indication of when the treatment should begin. For example:

> Psychotherapy, predominantly expressive in type, to be begun as soon as the patient has made significant progress in her industrial assignments. Twice a week to begin with in a doctor's office. A female therapist is recommended because the patient is childishly fearful of men and very much needs the opportunity of identification with a healthier-minded representative of her own sex than was her mother.

Counseling: The attending psychiatrist will undoubtedly advise the patient in regard to many matters during his successive visits with him. In many cases, however, help can be obtained from experts in other fields, particularly education, religion, marital relations, vocational choice and rehabilitation. A psychiatrist cannot and should not presume to be expert, or even well informed, in all these special fields, but he should be able to recognize when a patient is likely to be helped by such advice, and to recommend to him that he get it. Perhaps this is most frequently true in matters of religious uncertainty. Also a surprising number of individuals really do not know what educational, cultural or rehabilitation opportunities exist. These can be pointed out by the examining psychiatrist once he discovers his patient's need. Sometimes it is better to defer a communication of this type or recommendation until a certain point in the development of the therapy.

Group activities: The reinforcing effect of the progress of one individual upon that of a companion engaged in a similar effort is such a common observation in hospital work that it frequently gets less credit than it deserves. It is capitalized upon, of course, in the structured activities discussed under milieu therapy. But even in the outpatient department, without the special milieu features, there is a group effect which can be used. It is formally recognized in group psychotherapy, group drama, group project work and other group activities which are available to both inpatients and outpatients. Perhaps the most effective example is that of Alcoholics Anonymous. All such resources should be known and utilized by the psychiatrist, by design and by prescription.

Through the ages the church has been the single strongest and most universal group agency. As represented either by formal church groups or by various kinds of other religious organizations or by their chaplains, they should be used to the extent indicated by the patient's needs and attitudes. Religious counseling has been mentioned above, but here I am speaking of the need to belong to something, which all individuals exhibit to various degrees.

For certain patients group psychotherapy is sometimes regarded as the treatment of choice. Patients who are unable to tolerate the intensity and closeness of a one-to-one relationship, or adolescents who tend to be more susceptible to peer pressures than to the pressures of an adult, are often best treated by this method. Like individual psychotherapy, the group method relies largely upon the use of transference as a major vehicle of treatment. Transference in this setting, however, is "multiple" in that it not only includes the relationship to the therapist but to the other individuals in the group as well. Obviously the group method is not capable of the kind of detailed and systematic study of transference disorders and their genetic roots in each individual patient that is aimed for in psychoanalytic treatment. Transference in its depth and in its regressive character is more in the background in the group situation. On the other hand, immediate here-and-now interactions, conflicts, and tensions are brought into sharp relief, often very dramatically, within a group. The insights and corrective experiences that result from such situations are capable of contributing to decisive personal readjustments.

Group psychotherapy has certain potential values common to many group activities which are easily recognized. Patients are given an opportunity to overcome their loneliness and isolation in a relatively protective setting regulated by a therapist. They experience great relief in finding that they are not alone in their neurotic suffering and in their heretofore unrevealed, shameful thoughts and wishes. Many are able to learn that the venting of anger is not necessarily destructive of their relationships. They find that they can be respected and accepted by others despite their weaknesses and defects.

Changes in Treatment Plan

As the treatment and observation of a patient proceed, changes occur. The patient may get better or he may get worse. The psychiatrist may alter his formulation of the diagnostic synthesis after further study, or after consultation. Additional disclosures about the patient's life and his disorganization may change the picture.

The doctor(s) must review the treatment program at regular intervals, the frequency ranging from every day or two to once every two months according to the activity occurring in and around the case and according to the patient's progress. The doctor correlates his current understanding with the prescribed treatment program and decides whether all its phases are optimum for the patient's present treatment needs. When the evidence favors changes in the program the doctor records the proposed modifications in the progress notes and the reasons for them, and he takes the steps necessary to initiate them.

Staff Communication about Treatment

Collaboration and communications among the professional people who conduct the treatment program are of crucial importance. In psychiatric hospitals understanding among the many participants in the program about the objectives and methods of the treatment and the kind of observations pertinent to management of the case is essential. This holds true of psychiatric treatment in any setting where professional workers, other than a lone psychia-

trist, contribute. Each member of the group must be aware of necessary special precautions, the needed degree and kind of supervision and the attitudes prescribed to counter the patient's tendency to invite reactions which help perpetuate his illness. Each member of the group must be alert to the patient's reactions and be prepared to report them as well as any problems which may occur in carrying out the treatment.

The task, then, consists of developing ways of communication among team members. Conferences and written communications can inform each staff member in a manner which permits him to implement his part of the treatment. They also allow staff members to report their observations of the patient's reactions. Each hospital or other formal setting for psychiatric treatment develops its own conference plan and its own forms for written communications.

In practice, a professional group concerned with a treatment program clarifies the requests through discussion both in regularly scheduled conferences and in unscheduled informal meetings. In a hospital, the psychiatrist usually makes rounds at regular intervals to talk individually with nurses, aides, adjunctive therapists, social In this way, he can acknowledge and indicate his response to inforworkers. and others who form the collaborating treatment group. mation received from these sources. Communication must always be a two-way process.

Discharge

Separation Planning

Whether a patient is in a controlled therapeutic environment such as a hospital, or is receiving once-a-week psychotherapy or six-times-a-week psychoanalysis, thought should be given from the very beginning of the treatment to the matter of its ultimate termination. Casework with the relatives, done either by the social workers or by the psychiatrist himself, is already initiated at the time of the patient's admission to treatment. It will continue throughout the patient's treatment and perhaps come to a climax when the point is reached when the patient can be dismissed from further contacts with the therapeutic efforts of the physician or clinic or hos-

pital. During the treatment and again at the time of its termination some relatives will need encouragement, while others will need caution against too much optimism or too high a level of aspiration with reference to the patient's development. It is difficult to say which of these attitudes causes the more harm.

But even more than guidance about what to expect and what not to expect, relatives need enlightenment as to the role they have played and do play, and the different role which they might play in the future. This and other details of casework with relatives have been developed by the psychiatric social workers. They are careful not to describe what they do as treatment, first because those whom the social workers treat are not patients, and secondly because the social workers do not attempt to give treatment in the medical sense. Nevertheless, this help to the relatives is indeed often therapeutic for them as well as contributory to making the therapy of the patient more promising and more permanent.

The physician needs to remember, first of all, that such casework must be done, and should be definitely arranged for. Secondly, he must keep in touch with it. It is not enough to refer such matters to the social worker and then be provoked or indignant because misunderstandings arise. Lines of communication with the relatives must be kept open, either directly or through the social workers; in the latter case the physician and the social workers must cooperate and communicate. Each of them is likely to discover facts of considerable importance to the other which should not be concealed.

The ultimate discharge of the patient from treatment hinges upon his improvement or recovery, or upon his dissatisfaction with the treatment, or upon the dissatisfaction of his relatives with the treatment or with his reactions to it. These contingencies usually cannot be predicted at the time the treatment prescription is being written.

There are often, however, certain facts or persons or situations known to the physician at the time of the case study that strongly condition the circumstances of the termination of the treatment. For example, it may be apparent from the beginning that the patient will never recover his sight, or that he will not be able to remarry, or that he will have to return to the same cold, harsh situa-

tion as before. A knowledge of these facts will guide the physician and the social worker in placing proper limits on their own expectations as well as those of the relatives.

Limitations may appear suddenly in unexpected ways in the development of complications of various kinds which make it necessary to terminate the treatment sharply. These sad events are fortunately not too frequent.

Progressive Discharge

The final steps for the patient's discharge from the hospital may not be visualized at the time of the prescription of treatment. But sometimes it is possible to visualize them. For example, foster home planning may be visualized and must be looked forward to many months in advance because of the difficulties of arranging it. Day hospital arrangements are frequently used now as a stepping-stone to a complete return.

On the other hand, there are some matters in regard to discharge planning which are known at the time of the diagnostic case study. We usually know, for example, who the patient's family physician is, or his personal psychiatrist in another city. We shall be corresponding with this doctor, and when the patient leaves we shall have some further recommendations to make. He needs to know from the very beginning what has been found, what is being done and what is being planned for him when he does go to day hospital status or to outpatient status or to home treatment status.

The time will come when a patient passes out of the range of immediate observation by the physician. In one sense a physician remains his patient's doctor as long as the patient needs and claims him, even though some years of silence intervene. But in practice, cases are officially terminated at some point, so far as the treatment program is concerned. They may be referred to another physician or agency, transferred to another hospital, dismissed to the referring physician or the family, or discharged as cured. In any case a final note and discharge summary should be written by the physician.

This is of great importance for both scientific and legal reasons. The patient may return and require more treatment, and it is very helpful to know precisely under what circumstances he interrupted treatment. Some patients later forget the circumstances under

which they were discharged and develop various complaints or reproaches. Sometimes this is true of the relatives or others connected with the patient. Again, if an emergency develops, or if certain follow-up events occur which require quick review of a case record by someone strange to the case and ignorant of the circumstances of the patient's discharge, these summaries are of great help.

Continuing Contacts with the Referring Physician

In the discharge planning, one must remember that in most instances the psychiatrist's patient is also the patient of some other physician. The patient has often been referred by this physician for temporary psychiatric study or treatment; sometimes the patient has come without consulting his family physician. But American medical practice is built around the principle that the patient has a doctor, and the patient is that doctor's continuing charge, and that doctor is not always a specialist. The specialist, on the other hand, has certain advantages in the limitation of his work, but he has these limitations in part by virtue of the understanding that he does not become proprietary toward patients. They are *his* only temporarily.

The patient's physician is kept in mind not merely out of consideration of professional courtesy and medical custom. The family physician usually is in a much better position to be helpful to the patient over the long span of life than is a psychiatrist—if for no other reason than that he is closer to him. Because psychiatrists often maintain contact with a patient for a considerable length of time, they sometimes forget this principle. I think it is very important for the psychiatrist to keep in touch with the patient's home physician, and in the first edition of this *Manual* an entire chapter was devoted to the problem and to the referral of patients. Since the appearance of that chapter the matter has been earnestly discussed at numerous psychiatric meetings and the increase in the prestige of the general practitioner in American medicine has made the discussion all the more timely. I shall carry over some of the discussion from that previous chapter.

Every time a patient is accepted for either diagnostic study or treatment, the psychiatrist should ask himself the following questions:

Did I acknowledge to the referring physician the arrival of the patient he sent me, promptly and with an expression of appreciation of the confidence shown in me by the referral?

Did I write to him my idea of the diagnosis after I had studied the patient for awhile, and did I outline for him my ideas regarding the most promising type of treatment?

Did I get his concurrence in the plan, or did I at least make him fully aware of my intentions so that he could meet appropriately the doubts and anxieties and questions of the relatives who will surely be coming to him with their worries?

Have I kept him posted from time to time on the developments in the course of the patient's treatment with me?

Have I let him know that the patient is about to come home soon, and did I make it clear to him that I am telling the patient to go and see him?

Have I planned to write to him in detail regarding suggestions for the continued treatment of the patient by him after the patient's return home?

Did I explain to him just what my own subsequent role in the patient's life might be, after the patient has gone back to him?

In fact, and in a word, in the study and treatment and discharge of this patient, did I consider the local physician at all, or did I just consider him a nonentity and quietly steal his patient?

Some psychiatrists do not want to cooperate with referring physicians, and perhaps some referring physicians do not want them to. But it is the time-honored, ideal way to practice medicine. The patient lives in a town where the doctor represents the healing art, and it is bad psychologically for the patient to feel that in point of medical care he is not a part of that community. We doctors all have pride in the fact that we are trusted and consulted by suffering people, that we are recognized as having something to offer and that we sometimes help people. If a doctor in a community recognizes that he does not have what a particular patient needs, and recognizes that a psychiatric colleague does have it, and if then he is honest enough to send his patient to a psychiatrist to get that help, the doctor is doing the patient a favor at the cost of some self-renunciation. The doctor is doing the psychiatrist a favor only in his selection of the particular psychiatrist whom he thinks can be most helpful to the patient.

Today the situation is complicated because whereas we psychiatrists used to be grateful to any physician who would refer a patient to us, the market is such that today it would seem as if doc-

tors were sometimes expected to be grateful if some psychiatrist would accept their patient! Actually we should not think of gratitude in either instance. The conscientious physician knows that some of his patients need care which he cannot give them. But he realizes that to obtain such care may be very expensive for the patient in time, in money, in prestige. He is often reluctant, therefore, to refer a patient; sometimes he is only too happy to get rid of a patient.

These difficulties the psychiatrist will bear in mind if he is thoughtful about the matter. He will put himself in the referring physician's place in cooperating with him, helping him in the subsequent treatment of this patient and even—if the opportunity presents—teaching him by demonstration how psychiatry looks at such matters.

Recapitulation of Treatment Prescription

An outline of the treatment plan should appear in the summary of the case study (to be discussed in Chapter VII) using the following general framework which summarizes the text of this prescription chapter.)

A. Initial Arrangements
   1. Place (home, hospital, office, etc.)
   2. Legal status
   3. Economic arrangements
   4. Attitudes of patient and relatives toward treatment

B. Somatic Therapy
   1. Medicinal (drugs, dose, frequency, purpose)
   2. Physical (type, frequency, purpose)
   3. Dietary (type, purpose)
   4. Dental (specify)
   5. Special (*e.g.*, ECT)

C. Psychological Therapy
   1. Psychotherapy (type, frequency, therapist)
   2. Counseling (educational, religious, vocational, marital, general—where and by whom)
   3. Group psychotherapy, psychodrama, group projects
   4. Extramural resources (church, schools, AA)

D. Milieu Therapy (Controlled Therapeutic Environment)

1. Type of control required (hospital, school, day hospital, etc.)
2. Prescribed attitudes of milieu personnel toward patient
3. Milieu living arrangements; instructions to nurses concerning:
    (a) Contacts with aides and nurses
    (b) Contacts with other patients
    (c) Precautions against special dangers
4. Living-Learning program within the milieu:
    (a) Industrial
    (b) Educational
    (c) Recreational
    (d) Creative
5. Continuing extramural contacts (stipulations regarding telephone calls and visitors—with whom, whom not, frequency and duration)
6. Contacts with physician (frequency, duration, technique)

E. Separation Planning

1. Casework with relatives during patient's treatment (specify persons, aims, emphasis)
2. Conditional factors preventing, limiting or impelling discharge of patient
3. Projected program of discharge steps (passes, trial visits, halfway house, day hospital, another hospital, another clinic)
4. Recommendations already apparent regarding discharge: *e.g.*, changes necessary in environment, treatment by another agency, ultimate referral to colleagues, *etc.*

CHAPTER VI

Charting the Course of Illness

It is every physician's hope that the strange, adventitious state of being which brought the patient into medical purview will pass through its various stages of evolution and involution and disappear. The physician endeavors to expedite and hasten this happy outcome. To this end the case study was made and the treatment program instituted.

But neither diagnosis nor treatment plans stand still. Changes keep taking place in the patient, in the environment and in the physician. Every ship has its navigation log, for well-known purposes, and every patient who has been launched on a course of treatment should have the benefit of careful, conscientious charting for the same reasons. It is necessary to know where we are and where we are going, and how—if at all—we should change our course.

Whether to record observations daily, or weekly, or once a month depends upon the acuteness of the case, the rapidity of change and many other circumstances. In any case these notes should, from time to time, and certainly not less often than quarterly, be reviewed and summarized. This is an additional task which may seem to add to the already heavy burdens of paper work. But such periodic reviews assist in getting an over-all view of the course of the illness and frequently make subsequent note writing easier.

Progress notes, to be of any value, must be *legible*. Handwritten notes are better than dictated notes. Dictation is a skill and some doctors never acquire it. Dictation facilities are no sanction for loose, rambling, verbose compositions which are just as illegible—in a different sense—as undecipherable scribbling.

All notes should be *dated* and *signed*—not initialed. In the case of typing-pool transcription, the date of dictation is the important one; and typists should be instructed about this. Esoteric abbreviations are to be eschewed, and indeed, all abbreviations which are not highly conventionalized.

Finally, the avoidance of clichés is important and curiously difficult in the recording of progress notes. Such banalities as "The patient continues to make progress" "Condition unchanged" "A fair week" "Patient very disturbed" should be banned. They are not in themselves wrong, but they are so hackneyed and so vague that they bespeak a doctor poorly oriented with respect to his patient's progress, or one too busy, too lazy, or too inarticulate to define that progress intelligently.

The importance of this clinical navigation record might seem to be most obvious, yet it constitutes one of the weakest features in most psychiatric reports. Progress notes often tend to be unsystematic, irregular, verbose, trite, cryptic, repetitious, or (and perhaps this is the most common) lacking altogether. Observational notes recorded by nurses, aides and therapists are sometimes included in the record *in toto* rather than being incorporated in the doctor's notes. Fortunately, the modern trend is for nurses to do less writing and more listening and participating.

From time to time, waves of reformation and new resolution sweep through hospital staffs. It will be discovered that progress notes are being neglected and there will suddenly be a great many of them—for a while. Then comes a pressure of clinical duties, or administrative complication, and it is unanimously agreed that there is "too much paper work." A few glaring examples of prolixity and verbosity will be exhibited, some long, rambling "process" notes or other glaring examples submitted, and the net result will be a curtailing of paper work, *especially progress notes.* And this is the area which can least afford curtailment.

We cannot observe everything or record everything; therefore, some point of view has to guide what is recorded. A dependable guiding idea could be a fairly systematic, successive analysis of how the patient responds to the prescribed treatment program.

Graphic Records

When all is said and done, however, words are weak tools for accurately describing the nature and the speed of change in the illness process. It is difficult to convey accurately the picture of a patient's course of illness. Various kinds of data must be combined

and organized into a related series of assertions properly geared to a time scale. Many physicians only succeed in giving the impression of being "over-identified" with their patient in whom they see what they hope. It is important to have as clear and definite a record as possible of how the case is going, but such records are not easily made.

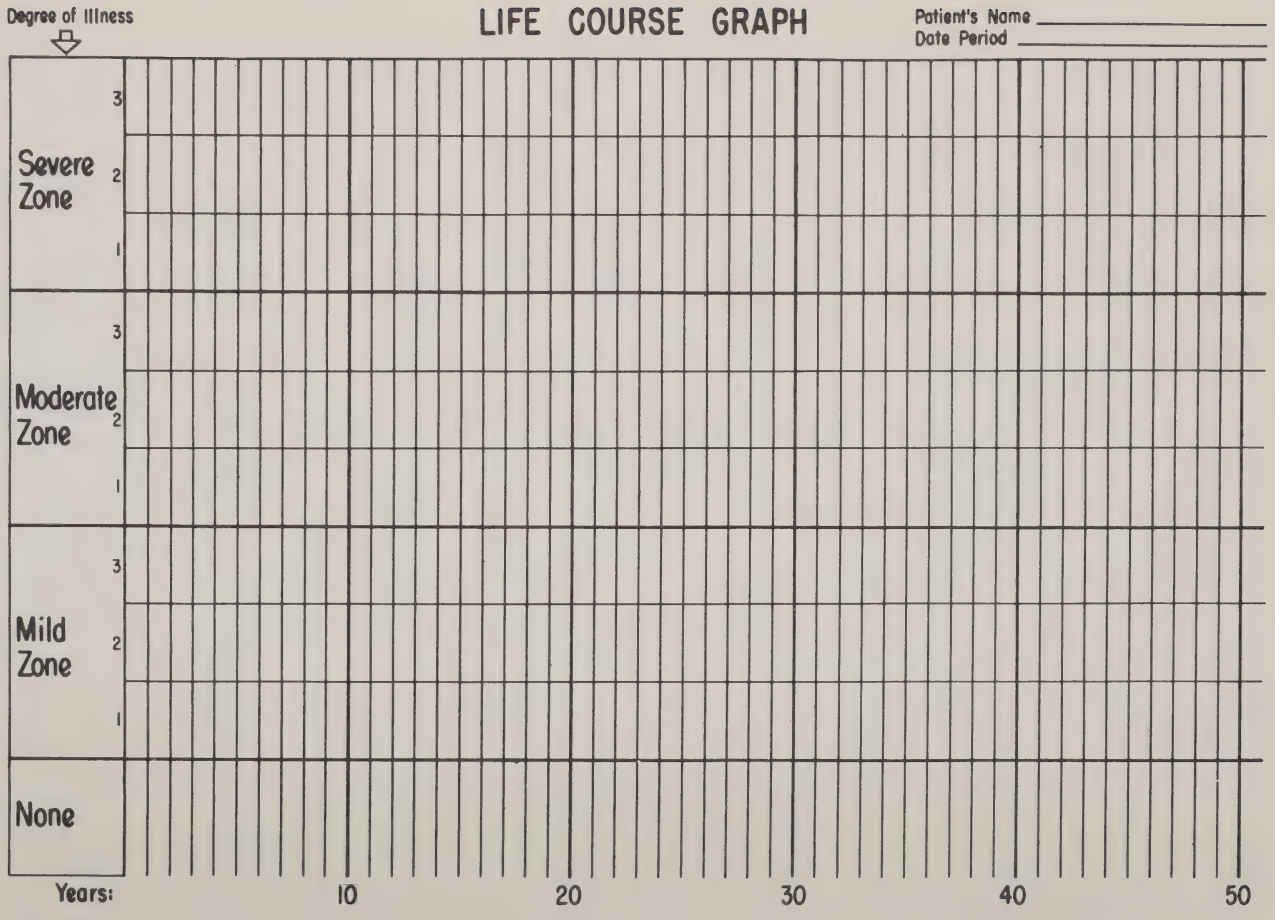
One way of conveying a picture of the course of illness is to borrow a device familiar to every physician and nurse in the form of temperature, pulse and respiration charts. This was mentioned in Chapter IV (page 92) in connection with diagnostic studies. Now we should like to say a little more about it as a method of recording continuous observation.

Several practical difficulties confront us in constructing a chart which will accurately reflect the course of a psychiatric illness. One of these* is that psychiatric illnesses may last a day, a year, or half a lifetime, and hence the time scale for plotting its course has to be flexible. We propose three different time scales and hence three different charts, comparable to the three different objectives on a microscope. If one has sufficient historical data, or if one has been in a position to observe a patient for a long time, he can construct a graph describing the fluctuations of the satisfactoriness of the adjustment in life over fifty years. Hence one scale must be in the nature of a long range or low power view of the patient's *Life Course*. (See Fig. 1.)

Usually physicians are concerned most intimately with the present illness, the phase of disorganization which brought the patient to seek help. We like to hope that this phase is fairly recent in its acute development, and will be swift in its involution. Psychiatric illnesses can, indeed, last a lifetime, but most of them disappear within a year, and the vast majority of them within three years. Hence a chart which will cover a three to five year span will usually suffice. This chart could be designated the *Present Illness Graph*. (See Fig. 2.)

Finally, for patients in whom changes are taking place very rapidly, or in whom changes are *expected* following specific treatment measures, or for patients under intensive study for research purposes, it is desirable to have a close-up or high-power microscopic

* Some of the other practical difficulties will be discussed later in the chapter.



MF-559 (3-62).

FIGURE 1

Degree of Illness
PRESENT ILLNESS GRAPH
Patient's Name
Date Period
Severe Zone
3
2
1
Moderate Zone
3
2
1
Mild Zone
3
2
1
None
Age
Before present examination
Under direct observation
MF-560 (3-62).

FIGURE 2

DAILY CLINICAL FLUCTUATIONS GRAPH

Patient's Name _____

Date Period _____

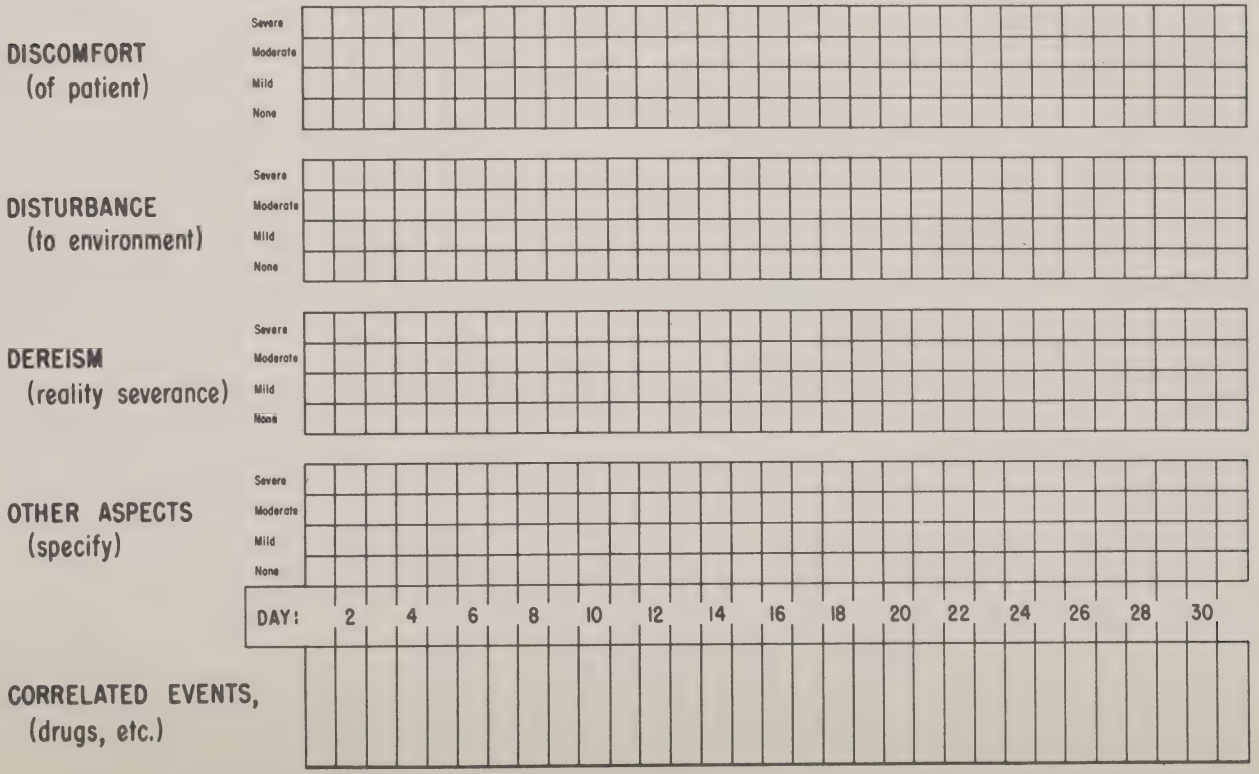


FIGURE 3

MF-561 (3-62).

analysis of the process, showing day-to-day changes in various aspects of the illness-recovery process. This chart might be called the *Daily Clinical Fluctuations Chart.* (See Fig. 3.)

Daily Clinical Fluctuations Chart

The psychiatrist must estimate the degree of internal disorganization reflected by symptoms and unsatisfactory "coping" efforts. The patient's clinical course is constantly under surveillance based on the sequence of day-to-day observations.

A symptom persists or it recedes; the depression, or anxiety may increase, or may remain about the same or may diminish; the patient becomes more disturbed and disturbing, or perhaps detectably less so. These various aspects of the illness often develop either a parallel or a reciprocal relationship.

All of this becomes clear if some effort is made to keep a daily quantitative record in graphic form. Quibblers will complain that even in a single day a patient may show many fluctuations. But in most cases the illness is not that labile. And certainly it is easier to estimate a prevalent or representative level of certain functions of any particular individual as observed in the course of one day, than it is to make estimates covering a month or a year. We constantly do the latter; why not try to do the former?

Three aspects of illness, all of them stemming from the disorganization, have been selected for daily quantitative estimation. For each of them a four-tier grill has been constructed, 31 days in length. The scale for each of these degrees of the illness is the same. The lowest tier represents the absence of that symptom. The next three tiers represent zones of MILD, MODERATE and SEVERE degrees of that manifestation. These zones are crossed at regular intervals by lines indicating the passage of another day.

The "Discomfort" matrix relates to the degree of the patient's suffering. This is the criterion by which the patient himself most frequently gauges the severity of his illness. True, some patients who suffer much complain little and vice versa; hence the doctor and the nurse must try to indicate what they believe to be the degree of pain present—slight, medium or great; in the terms we have chosen, MILD, MODERATE or SEVERE. Of course in many cases

it is absent altogether, in which case a dot would be put in the zero zone instead of in one of those above it.

To provide a common standard by which to make these judgments, and insure some minimum comparability of ratings made by two or more individuals, a rating scale has been devised by which to "measure" the patient's subjective distress. (See Scale 1 which follows.)

Scale 1

Degrees of Subjective Discomfort

1. MILD

The person's sense of well-being and self-fulfillment are marred or interrupted only occasionally by inner tensions or outer pressures. Sometimes he may feel a lack of zest for life, or even somewhat uncomfortable, but he does not consider himself sick and in need of help.

We may identify three degrees of departure from the "ideal" level of well-being:

1.1. The person feels occasional tensions and uneasiness in particular situations, like being in a large group of people, meeting his boss, etc. The bulk of his life activities continues to afford him reasonably rich satisfactions and self-fulfillment.

1.2. A neutral or dull mood usually prevails rather than a zestful one, but without any accompanying anxiety or depression.

1.3. Inner conflicts make themselves felt in recurrent, but not frequent, episodes of anxiety or depression, which though transitory may be quite unpleasant. An undercurrent mood of mild anxiety or depression may insinuate itself into previously pleasant experiences.

2. MODERATE

At this level, the distress will have become so pronounced that the person cannot escape being painfully aware that something is wrong. This awareness may be tempered somewhat by one or another form of insensitivity to one's inner feelings, but even a "high threshold" to feelings of emotional distress may be ineffective in forestalling a sense of subjective distress. The doctor should try to gauge as well as possible the degree of inner distress uncolored by the façade which the patient presents (of either minimizing or exaggerating his discomfort).

Three degrees of subjective disturbance may be identified in this middle range of subjective distress:

2.1. Inner conflicts now clearly impair the ability to find satisfaction in work and play. Uneasiness or heaviness of mood now represent the most prevalent mood. There is no doubt in the person's mind that something is wrong with him, but he may not be in acute distress, or is in acute distress only when his neurotic defenses are threatened.

2.2. Anxiety or depression are experienced with painful intensity. Most or all of the zest for living is gone; there may be a persistent sense of futility; few if any activities or diversions can lift the person from this mood except perhaps on very infrequent occasions.

2.3. The person may at times be in a state of intense, diffuse anxiety, bordering on panic. The person may feel acutely the need for help if he is to free himself from this state.

3. SEVERE

At this most severe level of subjective distress the person either verges on a sense of desperation or actually feels desperate. The nature of the fears or the depression is such as to suggest that the person's defense-structure is undergoing serious rupture or collapse.

3.1. The patient seems to be directing most or all of his efforts to defending himself against feelings of panic or despair which threaten to overwhelm him. The eruptive conscious distress may take any of a variety of forms: fear-tinged feelings of estrangement or depersonalization; an acute panicky fear of impending catastrophe; hopelessness over ever being able to free himself of his crippling symptoms; or a deep depression which leaves the person with a marked lethargy and disinterest in life.

3.2. Despair or even torment prevails. The patient is likely to be actively suicidal, determined to put an end to his miseries.

3.3. Wild panic or abysmal despair.

Whatever doubt there may be about the discomfort suffered by the patient, there can be little about that experienced by the environment. How much social discomfiture does the patient cause? How much does he disturb other patients? How much does he upset the hospital routine? In the common language of hospital personnel, how disturbing is he? (In some instances such information must come from relatives, fellow employees, friends and others with whom the patient has been in contact outside the hospital.)

To chart this, instead of writing a nursing note which describes the patient as "unceasingly asking the nurse for cigarettes, medicines and special privileges and complains to the other patients of the poor service in the hospital, through drawing attention to himself

from various quarters, mostly adverse," the psychiatrist or nurse would need only make one simple ink dot, with a word or two of explanation jotted in the margin. But a series of these dots made day after day will clearly show the trend of this manifestation of the illness.

Scale 2

Degrees of Interpersonal Disruption

1. MILD

At this level of disorder, the person still maintains a favorable "trade balance" in that commodity of warmth, love, interest, libido or whatever one chooses to call the "currency" of social intercourse. He can still give more than he needs to receive. But this capacity to give of himself may begin to show signs of strain; he may be giving less and needing more. We can distinguish three degrees of departure from the ideal of warmth, spontaneity and ease of contact with others:

1.1. The person seems less interested in keeping up all of his social contacts. He may spend more time in solitary pursuits, although people still seek and enjoy his company, and he continues to need and enjoy the company of his closest friends. His tendency to withdraw from social commitments does not disturb his family ties; his wife and children remain for him the most important people in his life.

1.2. The tendency to withdraw from social contacts is more pronounced so that the person narrows his circle of friends to one or two intimates, or even down to the members of his immediate family. He may begin to show other signs of strain on occasion: irritability, tension, impatience in social relationships. He does not become actively unfriendly; he is just not as friendly as he used to be.

1.3. The strain of maintaining his previous level of social intercourse seems to be taxed to the breaking point at times. He finds it difficult to maintain his earlier warmth and spontaneity, though he still tries. There are occasions when he seems unable or unwilling to "contact" others. He may disappoint others unexpectedly at times, and it is fairly easy for him to grow suddenly impatient, provocative, irritable and moody.

2. MODERATE

The person now clearly needs more warmth than he is willing to give to others. He grows increasingly hard to live with and harder to like. He is increasingly thought of as burdensome, demanding, inconsiderate, cold or selfish. If this has been the level of his social intercourse for a

long period of time, he may have found it difficult to find or to keep a wife (or husband).

2.1. The person seems unable to give others that minimum response of warmth, appreciation or interest which sufficiently compensates them for their attentions, so that they do not become resentful over all they are called upon to give him of their patience and love. He seems to have given up the initiative in seeking out old friends or making new ones. He finds it too difficult to do his part in sustaining relationships initiated by others. He is not considered to be a loving husband and parent, though he continues to do his duty by his family.

2.2. The person is not only unable to give, as described in the previous paragraph, but he is also actively demanding and self-centered. He may insistently complain of his symptoms and expect others to cater to his every need. He is considered disagreeably burdensome by even his wife or his closest friends. He may occasionally have loud tantrums of rage or self-pity.

2.3. The person impresses people as being artificial, or shallow, or cold, or selfish. He may be looked upon as a lone wolf whom people shy away from. He seems to have little regard for social sanctions or obligations. People—even those who may have been friendly earlier—try to avoid him because he has become so unpleasant by his leechlike clinging, or his rudeness and hostility, or his coldness and disinterest.

3. SEVERE

The person now is so taxing to others that he is considered unmanageable in the social community. He demands or needs too much support or toleration. His rages may be frightening or even dangerous. The kind of control or nursing care he needs may be available only in a hospital or a special environment. The asocial or antisocial behavior may require institutionalization for the protection of himself as well as others.

3.1. The family or friends feel with justification that the patient's behavior has grown too burdensome to tolerate further at home; they feel that the problem has progressed to a point where they must turn it over to specialists who are better equipped to take over responsibility for the patient. These symptoms may be of various kinds: minor misdemeanors, highly provocative behavior, addiction to alcohol or drugs, or even as phobias, compulsions, etc., which are present to a rather incapacitating extent.

3.2. The patient may be institutionalized not by choice but by necessity. His symptoms are such that the community finds them obnoxious or frightening and would file complaints if the patient were not kept in isolation. Or the person may have committed a felony and be required by the law to be placed in isolation for a considerable period of time. In either event, the decision to isolate the person is made by the courts and taken out of the hands of the person, his family or friends.

3.3. Even in the more restrictive and supporting institutional setting, the person is considered to be a "management problem." He needs constant supervision. He may indulge freely in grossly destructive or antisocial behavior, or he may do little or nothing to care for himself even in the most elementary details of personal hygiene.

At least one more aspect of the illness must be appraised. A truism of psychiatry is that neither a patient's words nor his actions, taken by themselves, tell the whole story of his illness. Indeed, the patient is a psychiatric patient because some of his behavior and some of his thinking have become distorted in ways which he may not even recognize himself. Threats of disintegration which he has experienced have been met by the erection of various emergency coping devices or regulatory mechanisms (compensatory functions, defense measures). We have proposed elsewhere that these phenomena can be arranged in hierarchical orders corresponding to various successive levels of disorganization. First, Second, Third and Fourth Order devices have been identified as corresponding approximately to increasing degrees of disorganization. Whether or not a psychiatrist wishes to use these terms, he should, and will, undoubtedly, attempt to estimate the severity of the illness by the intensity of certain symptoms on an empirical basis.

Thus, conspicuous symptoms may occur with minimal disability and with or without suffering, but many years of accumulated psychiatric observations have given a basis for judging these. Most of us would rate a quietly expressed paranoid delusion, for example, as (usually) far more ominous than a noisy outburst of anger. The determining essence of all psychopathology is the degree to which it represents disloyalty to reality and severance from it. First Order devices are usually seen with nominal dereism; Second Order devices with slight but definite reality denial; Third Order devices with episodic relinquishing of nearly all contact with reality, followed by a resumption of good contact; and Fourth Order devices by extreme withdrawal, denial or distortion. Again, in terms of the approximations of everyday language no longer appropriate in scientific description these are the zones of "nervousness," "neurosis" and "psychosis," with the added complication of episodic cases

which may be any, all, or none of the former. For more precise scaling of this aspect of an illness, Scale 3 is recommended.*

Scale 3

Degrees of Disorganization

1. MILD: (Largely first order equilibrating devices manifest)

According to our theory this "stage" represents a slightly excessive, and hence noticeable, over-use of the normal psychological stabilizing processes ("coping devices"), usually associated with some tension or "anxiety feelings." No significant *qualitative* changes in the social adjustment of the person, but the sexual adjustment may be moderately disturbed during periods of greatest stress.

1.1. The "mildest" mild. Heightened tension is felt, unpleasantly but not necessarily as apprehensiveness or "anxiety." Relative stability is maintained, but (only) with hyperactivity, hyper-emotionalism (irritability, weeping, etc.), hyper-compensation.

1.2. Tension is more noticeable to the patient and perhaps also to other people. Irritability, vague restlessness or uneasiness, vague or minor somatizations, and even sleeplessness may occur. These often come in bursts or waves, with subsequent temporary subsidence, indicating that recuperative powers are still strong.

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* At the time we were writing these paragraphs we had not seen Lawrence Kubie's stimulating analysis of the difficulties involved in the quantification of symptoms. The following quotations are representative.

". . . Do changes in the frequency of the washing in a hand-washing compulsion measure the severity of the neurotic process? Or does it measure rather the struggle that the man puts up against it? Or the amount of suffering which he experiences because of his symptom, or which he experiences through the unresolved problems which he displaces onto the symptom?

". . . Or, consider the life history of the individual with a rigid compulsion always to play the role of the benefactor. If he is fortunate enough to have grateful beneficiaries, his neurosis for years will cost him relatively little. But when the time comes, as it surely will, that his beneficiaries (be they family, friends, or associates) exploit him, leave him, turn on him, reject the implicit domination, or apart from this, when the time finally comes that the failure of his benevolence to attain its unconscious goals finally takes its toll, then suddenly his benevolence turns to gall and wormwood. Overnight this can precipitate a switch from benignity to a state of embittered, resentful depression." (Kubie, Lawrence S.: The Investigation of the Pharmacology of Psychological Processes. In Pennes, Harry H., ed.: *Psychopharmacology.* New York, Hoeber, 1958.)

The reader will note that in our scheme of graphing we have attempted to circumvent the difficulties presented by Kubie.

1.3. Acute discomfort; things are getting worse; apprehensiveness; spells of depression and undue fatigue. Help may be needed to avert more serious or more persistent symptoms.

2. MODERATE: (Largely second order devices* manifest)

The person now begins to make more radical readjustments in an effort to minimize the effects of the disruptive stress. Resiliency gives way to compromise, and the person sacrifices some function or some organ or some self-fulfilling area of his life and retreats to a more narrowly circumscribed range of living. The acute tension state diminishes when these "second order" symptoms develop (sometimes called "the binding of anxiety"). This is the level designated often as "neurotic." The self-limitation is always associated with repressed impulses or fantasies and often with unconsciously fantasied punishments associated with the affected organ or function (that is, he "suffers from reminiscences").

2.1. Specific symptoms become crystallized as "lines of defense," curtailing freedom sharply in certain circumscribed areas, but not resulting in any general incapacitation. Rather, these areas remain fairly circumscribed and permit the person to function adequately in other areas of his life (work, hobbies, social relationships). Typical symptoms: impotence, frigidity, obsession, compulsion, phobia, mild depression, work aversion.

2.2. Multiple symptoms of the kind listed in the preceding paragraph are present, or else a single severe symptom which seriously restricts the range of activities and the sources of pleasure available to the person. Symptoms have a more crippling effect. Symptomatic behavior that is really a veiled form of self-destruction (e.g., drinking) belongs in this category too, as do chronic depressions and chronic apathy states without disturbances in thought organization. Patients at this level must be distinguished from patients with "pseudo-neurotic schizophrenia" who will prove to be more autistic on careful examination.

2.3. The defenses fail to bring about a stable life adjustment. The criterion here should *not* be the degree of *conscious* anxiety which remains "unbound," but rather the evidence that the current adjustment is either tenuous or brittle, so that the patient may be close to a shift to a more disintegrative level of life adjustment, e.g., loss of friends or freedom due to his asocial or antisocial "acting out" or his complete loss of initiative; or else, tension so severe that a psychotic break becomes a very real danger, although signs of such impending ego rupture may be apparent only on psychological tests.

3. SEVERE: (The emergence of third and fourth order devices*)

* For a fuller discussion of these levels of disorganization, see Menninger, Karl: Psychological Aspects of the Organism under Stress: Part I. The Homeostatic Regulatory Function of the Ego. *J. Amer. Psa. Assn.* 2:67-106, 1954; Part II. The Regulatory Devices of Ego Under Major Stress. *J. Amer. Psa. Assn.* 2:280-310, 1954. Menninger, Karl and Mayman, Martin: Episodic Dyscontrol: A Third Order of Stress Adaptation. *Bull Menninger Clin.* 20:153-165. 1956.

The synthetic activity of the ego fails in some respects, and regressive, archaic forms of thinking or blindly impulsive-destructive behavior displaces rational socio-syntonic forms of behavior and thought.

3.1. Episodic rupture in reality contact (e.g., convulsions, suicidal urges, fugue states, violent rage outbursts, etc.) would represent the most benign form of level 3 symptoms, in which the break with reality is marked but transitory. Borderline psychotic states without conspicuous dyscontrol also belong in this category.

The dereistic shift in one's relation to reality may take the form of bizarre fantasies or feelings of depersonalization, estrangement or impending world destruction. These dereistic symptoms may appear as ominous signs when thinking is not grossly disorganized, as in cases with "incipient schizophrenia." In such cases, the imminence of a more overt psychosis should determine whether to rate 2.3 or 3.1. These symptoms may or may not be associated with level 1 and level 2 symptoms.

Perversions or bizarre compulsive rituals often occur on the basis of a severe autistic or dereistic shift in object-ties, with associated disturbance in thought processes and reality contact. If such is the case, these phenomena fall into this category, even if the person presents a fairly good façade. Findings from psychological tests would be specially important for the evaluation of these and other cases of borderline schizophrenia.

3.2. Considerable and persistent repudiation of reality but with some "contact" preserved. The patient experiences schizophrenic hallucinations or delusions which he can still report to the examiner. Cases of "paranoia" and cases with manic flight of ideas also belong in this category.

3.3. Gross loss of contact; incoherent, bizarre, uncomprehending; vegetative regressed states.

As can be seen in Figure 3, there remains one additional matrix labeled "Other Aspects." This one is for the purpose of making comparative daily records and monthly graphs of particular aspects of the illness of the patient. This might be the degree of utilization made by the patient of various therapeutic programs. Or it might be the appearance of migraine, of dysmenorrhea, or of impulses toward self-mutilation. Correspondence between the pattern of this particular symptom and the more general evidences of the illness may be clearly suggested from the curves.

To identify these four matrices in another way, we might say that the first relates to what the patient complains of, the second to what those about him complain of, the third to what the psychiatrist or psychologist or psychiatric nurse is able to observe in the

way of psychopathology, and the fourth to any other particularly pertinent aspect of the illness.

This device for daily nursing records requires only four pencil dots per day and four dot-connecting lines drawn once a month! It will require a few minutes of thought, but certainly not more than thirty seconds to write. It will enable the psychiatrist to see at a glance the daily fluctuations in various aspects of the illness and the trend over a thirty-day period. Discrepancies, parallelisms, reciprocal or divergent curves—these can be seen clearly and, if a notation is made of certain special events, or administration of certain drugs, the possible connection with these events may be suggested from the corresponding changes in the shape of some, or all of the curves.

The Present Illness Graph

On the basis of the curves describing various aspects of the illness made on a day-to-day basis, the physician is able to construct a graph covering the full period of his observation of the patient. This may extend over months or even years. It will not be necessary to indicate the various components of the illness, because over a period of time the discomfort, the disability, the symptomatology and the social disturbance manifesting the illness will tend to merge, at least in their intimations of the intensity of the process. The discrepancies observable in a close-up view will not be apparent. The patient's principal way of showing his sickness usually persists and dominates, and its ups and downs constitute an approximate estimate of the degree of the disorganization present. However, if one likes, one can use different colored pencils or inks to draw the graphs of the fluctuations in several features of an illness process over a period of the several months or years of clinical observation.

The *Present Illness Graph* (Figure 2) is useful for purposes of continued treatment, where it is important to identify slight changes in the course of illness. With the aid of day-to-day observations and with the possibility of repeated first-hand examinations, we can make a much more accurate quantitative estimate of the illness as manifested at any particular moment, and with respect to the three aspects

of illness with which the psychiatrist is most often concerned—the discomfort of the patient, his discomfiture of others, and the degree of reality severance in the patient's illness.

In both the *Present Illness Graph* and the *Life Course Graph* (mentioned previously in connection with the *Case Summary* and shortly to be further described) ordinates similar to those in the close-up *Daily Fluctuations Chart* are used: NONE, MILD, MODERATE and SEVERE. The meaning of these is probably obvious. They label zones for: (1) no evidences of disorganization of any kind; (2) slight evidences of some disorganization or strong evidences of a slight disorganization; (3) definite evidences of considerable disorganization; and (4) evidences of severe disorganization. Young psychiatrists will probably continue to think of those zones in terms of "no illness," "nervous illness" (Zone 1), neurotic and psychosomatic illness (Zone 2) and "borderline" and psychotic illness (Zone 3), but for more precise definitions the reader is referred to Scale 1, pages 145-146.

A word is necessary regarding the episodic, explosive type of disorganization with quick *re*-organization and perhaps long intervening periods of quasi-normality. While one can sometimes show on the graph these sudden spikes of severe dyscontrol with evidences of only mild disorder, it is sometimes difficult to do so because the attacks come so frequently or so irregularly. These phenomena have to be weighted with respect to their frequency, the degree of self-destructiveness or outward aggressiveness in the attacks, the ameliorability of the diathesis by means of chemical control or other intervention, and other symptoms accompanying the attacks. Every physician has to estimate quantitatively from masses of heterogeneous data how severe a certain illness is. This is all that is required for approximate graphing of these cases.

The Life Course Graph

The *Life Course Graph* will necessarily consist of two parts: the part based on historical data and the part based on examinational and observational data. The patient was not seen by the physician during the early years of his life, but only during the examination and subsequently. Hence the first part will necessarily be much less dependable and much more of an approximation. The points

identified can, if desired, be connected with a dotted line or a line of a different color from that of the graph describing the *observed* course.

We need not be too apologetic about making a graph on the vicissitudes of adjustment on the basis of history rather than actual observation. To be sure, no history is completely accurate, and to be sure, we are in most instances accepting lay judgment and lay reporting. But it is unwise to discount this too severely. A divorce, an attempt at suicide, or a failure in school is likely to be almost as valid a datum if reported as if the psychiatrist had been there to see them occur.

The superb studies of Eli Ginzberg* and associates have shown us that records of work performance are more likely to lead to accurate predictions than are the data of brief psychiatric examinations. After all, we are not trying to define a patient's illness as of twenty years ago, but merely to determine whether there is evidence that he was slightly or more than slightly disorganized, a conclusion which can be reached with a fair degree of safety from a consideration of the remembered and reported maladjustment of that period.

Graphic records of a patient's life adjustments are considerably enlivened and illuminated if significant events are indicated by a legend on the chart at the appropriate points in time, marginally or cross-charted. We are always looking for evidences of a relationship between events presumed to have exerted strong pressures on the course of the illness and chronologically corresponding changes in the course of that illness, in either a disintegrative or reintegrative direction. Sometimes there can be no doubt of the relationship on the basis of chronological correspondence of the events plus empirical knowledge. If a patient's wife dies on June 1 and his former improvement shifts during June 4 to 30 to a progressive decline with increasing depression, it is more than presumptive that the exacerbation of the illness was related to the tragic event. Even this presumption may be wrong, however, as we all know from experience. The same is true of turns toward improvement, for which we are happy to take credit we sometimes do not deserve. The physician must attempt to weigh all the factors in balance, and to note what

* *The Ineffective Soldier; Lessons for Management and the Nation.* New York, Columbia University, 1959.

sorts of events seem to have, consistently, certain effects upon the course of illness. (These events may be treatment efforts, or they may be various kinds of trauma.) From this one gains an idea of how fluid, how unstable, the maladjustment is and how likely we are to bring about the desired shift of balance in the direction of encouraging the recovery trend. This is what is reflected in the statement of *prognosis* in the Case Summary.

It should also be remembered that there are other criteria for judging the trend of an illness than the psychopathology detected by the clinician. The Life Course Graph describes the changing levels of the balance struck between the disintegrative and reintegrative processes as observed *clinically.* But, often some of the most important observations about an illness concern the discrepancies which seem to exist between the appearance of the illness when viewed by the doctor, and its appearance to the patient and society. These, too, can be represented in the Life Course Chart with very little difficulty and with much potential gain to the doctor who is attempting to estimate the current trend of an illness.

To illustrate how this might be done, let us consider a hypothetical case. Figure 4 represents the health-sickness curve of a patient with no previous history of mental illness, whose present illness had a very gradual onset over a three-year period, not making itself apparent as an illness until 1958. However, in retrospect it was apparent that the illness had been developing gradually since 1954. This is represented in Figure 4 where for the sake of simplicity no attempt is made to show previous fluctuations in the patient's psychological equilibrium. Following the very gradual onset of the illness, the patient's condition abruptly worsened in 1957, forcing him to go to a hospital where he slipped further into an autistic and excited episode for which he received shock treatment followed by psychotherapy. He improved steadily and in 1960 was discharged from the hospital and has since shown no further symptoms of psychological disequilibration such as preceded the acute episode in 1958.

Figure 5 records a more multi-faceted view of this illness by the simultaneous use of the three scales referred to above. In what may be called the first phase of the illness, 1954-1955, there were no gross evidences of a psychiatric disorder, yet there were signs of

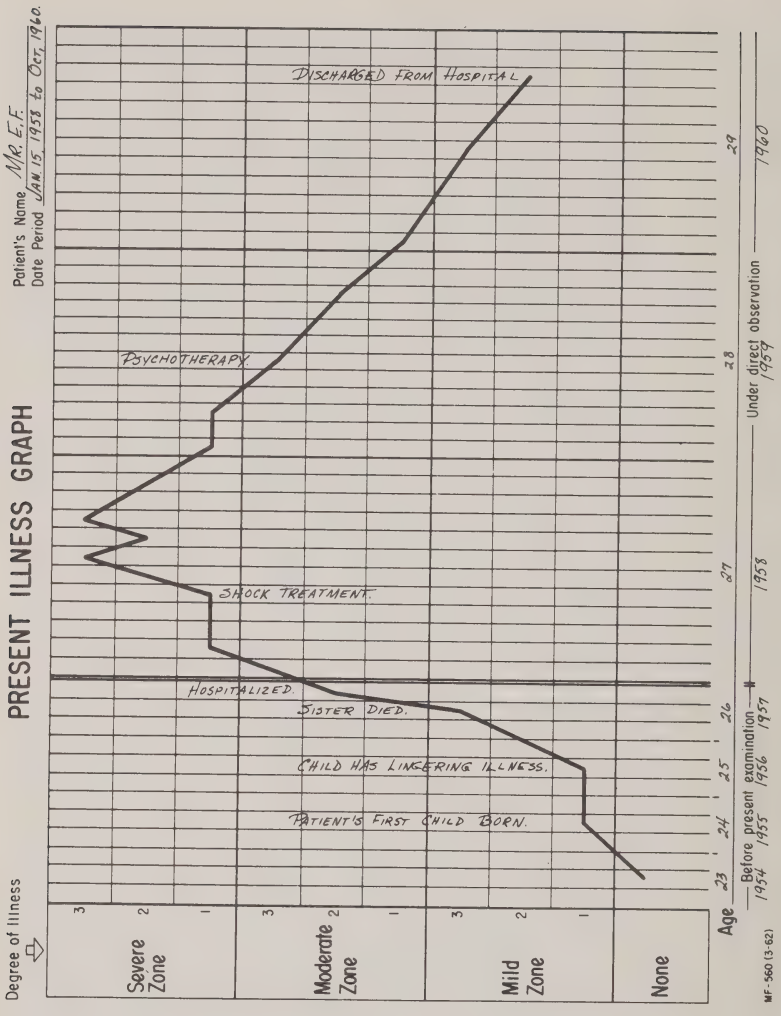
PRESENT ILLNESS GRAPH
Patient's Name M/R. E.F.
Date Period JAN 15, 1958 to Oct, 1960.
DISCHARGED FROM HOSPITAL
PSYCHOTHERAPY.
SHOCK TREATMENT.
HOSPITALIZED.
SISTER DIED.
CHILD HAS LINGERING ILLNESS.
PATIENT'S FIRST CHILD BORN.
Degree of Illness
Severe Zone
Moderate Zone
Mild Zone
None
Age
23 24 25 26 27 28 29
Before present examination
1954 1955 1956 1957 1958 1959 1960
Under direct observation
MF-560 (3-62)

FIGURE 4

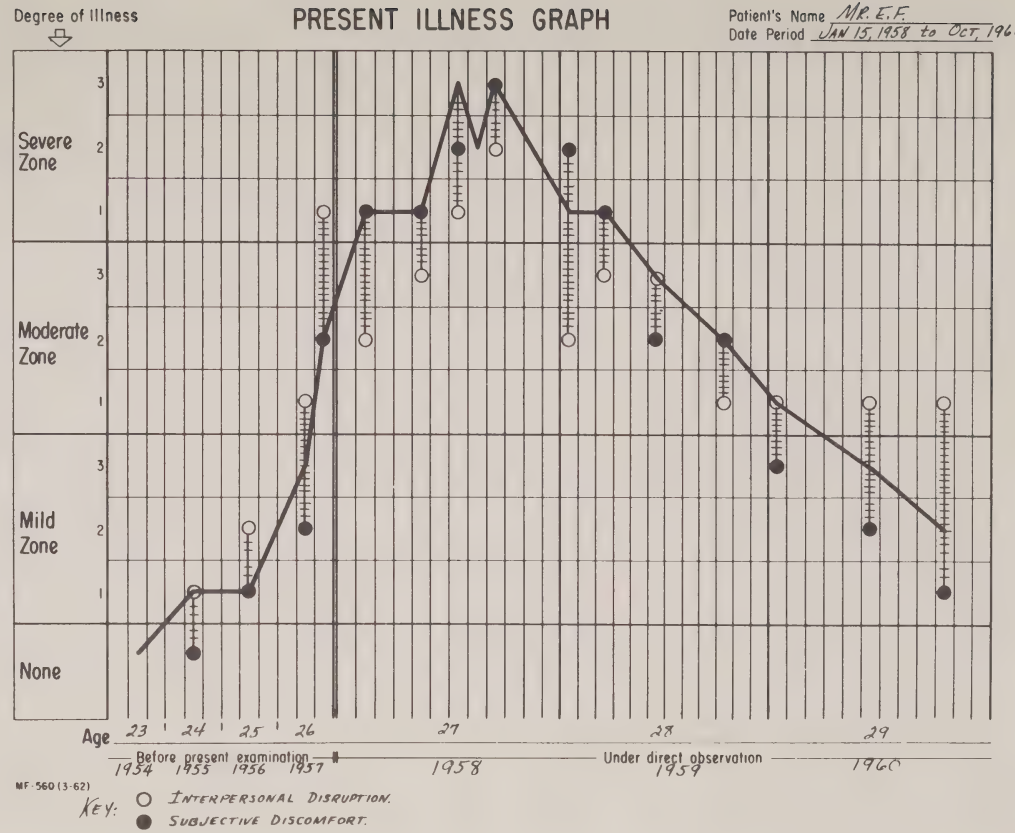
Degree of Illness
PRESENT ILLNESS GRAPH
Patient's Name MR. E.F.
Date Period JAN 15, 1958 to OCT, 1960.
Severe Zone
Moderate Zone
Mild Zone
None
3
2
1
Age 23 24 25 26 27 28 29
Before present examination
Under direct observation
1954 1955 1956 1957 1958 1959 1960
MF-560 (3-62)
KEY: INTERPERSONAL DISRUPTION.
SUBJECTIVE DISCOMFORT.

FIGURE 5

social and subjective disturbance which gave warning that all was not well. In 1956, the second phase of the illness made its appearance. The man became more obviously disturbed and felt even worse than he had during the past two years, but he continued to resist giving way to the illness (*cf.*, the social adjustment score), until the sharp break in 1957. Then in 1960 the illness entered its third phase, the almost equally rapid recovery, with the disappearance of all but a few subtle, residual signs of the recent personality rupture.

Function of the Graphs

Graphic records of the illness or illnesses and the lifelong adjustment and maladjustment of the patient have different kinds of usefulness. Their purpose is not to increase the physician's paper work but to diminish it, because they should provide a precise and quickly recorded history of the changes that have occurred, and those that occur under the physician's observation. Furthermore, they give an indication of the trend of the illness, and the speed of its evolution.

Speed is necessarily a relative term; the question is, relative to what? Relative to the human life span? Relative to the life expectation of the individual in question? Relative to the duration of this patient's illness prior to the point of discussion? Relative to the rapidity of recovery of other patients with similar appearing illnesses? Or relative to previous recoveries of this patient from other conditions of disorganization? One must bear in mind these varying referents of the adverbs *slowly* or *rapidly* when describing the progress of a patient either to relatives or to colleagues. When asked how long a psychoanalytic treatment would require, Freud used to reply that it was like traveling from Vienna to Berlin; the time depended upon whether one walked, rode or flew, and how many detours one made on the journey.

The use of the suggested graphs will necessarily be awkward to start with, and since they lack the precision which characterizes a temperature chart, they will make some compulsively accurate colleagues uncomfortable. But as psychiatrists continue to try to record their observations in this form, they will be working in the

direction of developing better measuring instruments, so that eventually they may approach the thermometer in reliability and exactness. For many years psychologists—and a very few psychiatrists—have been developing a science of rating-scale construction, and one may hope that this experience and some of the conclusions they have reached will be increasingly utilized in our efforts to be more precise in describing our clinical data and drawing the appropriate conclusions.*

Though based on only the crude, preliminary Scales recommended below, the sample charts shown as Figures 6, 7, 8, 9 and 10 are included to illustrate the use of this method in several actual case studies.

* The literature on psychometry is of course enormous. In clinical psychiatry there have been quite a number of efforts toward some kind of quantification. See, for example:

APA Mental Hospital Service Bull., Social Coding, 2:2, January 1951.

Barrabee, Paul; Barrabee, Edna L. and Finesinger, Jacob E.: A Normative Social Adjustment Scale. *Amer. J. Psychiat.*, 112:252-259, 1955.

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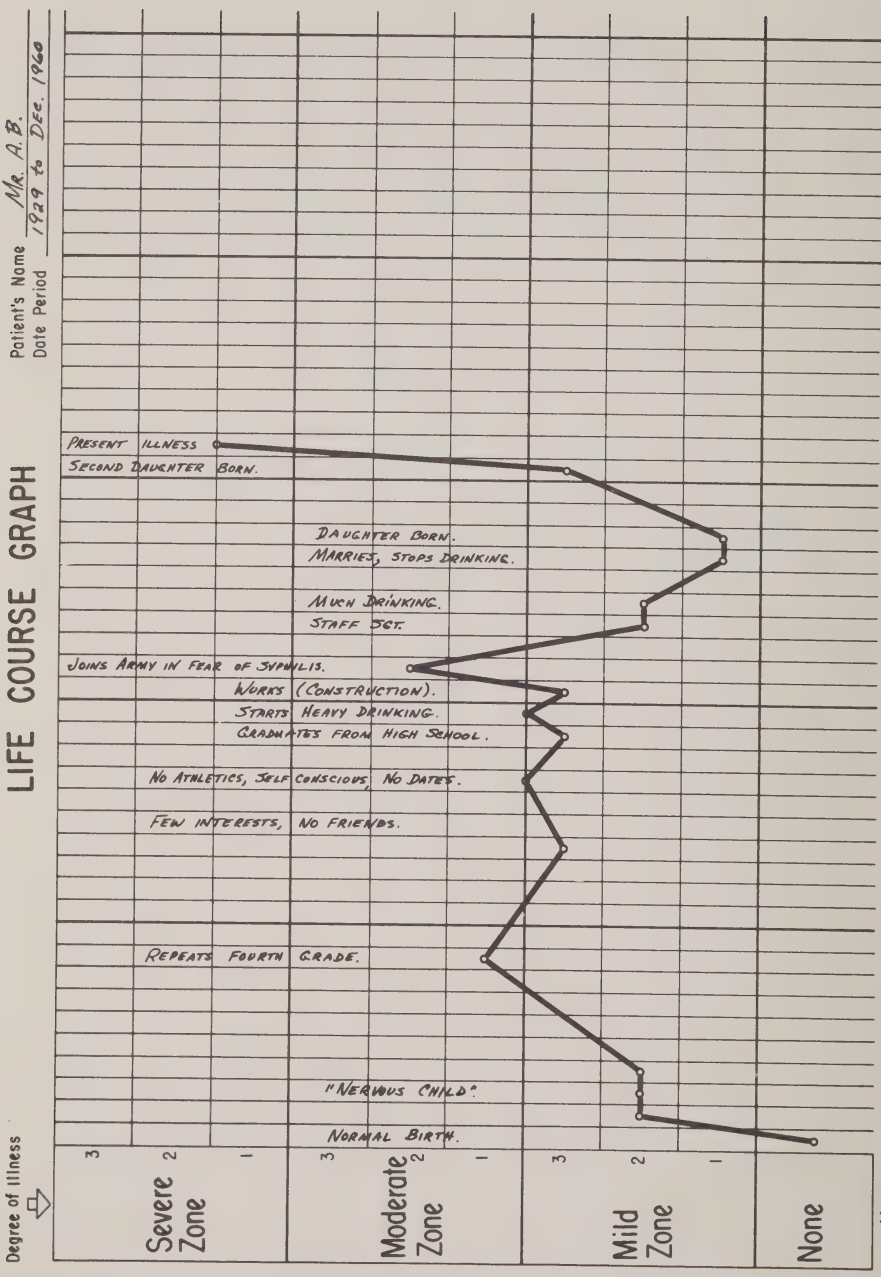

LIFE COURSE GRAPH
Patient's Name Mr. A.B.
Date Period 1929 to Dec. 1960
Degree of Illness
Severe Zone
Moderate Zone
Mild Zone
None
3
2
1
Years: 1929
10 1939
20 1949
30 1959
50
PRESENT ILLNESS
SECOND DAUGHTER BORN.
DAUGHTER BORN.
MARRIES, STOPS DRINKING.
MUCH DRINKING.
STAFF SGT.
JOINS ARMY IN FEAR OF SYPHILIS.
WORKS (CONSTRUCTION).
STARTS HEAVY DRINKING.
GRADUATES FROM HIGH SCHOOL.
NO ATHLETICS, SELF CONSCIOUS, NO DATES.
FEW INTERESTS, NO FRIENDS.
REPEATS FOURTH GRADE.
"NERVOUS CHILD"
NORMAL BIRTH.
MF-559 (3-62)

FIGURE 6

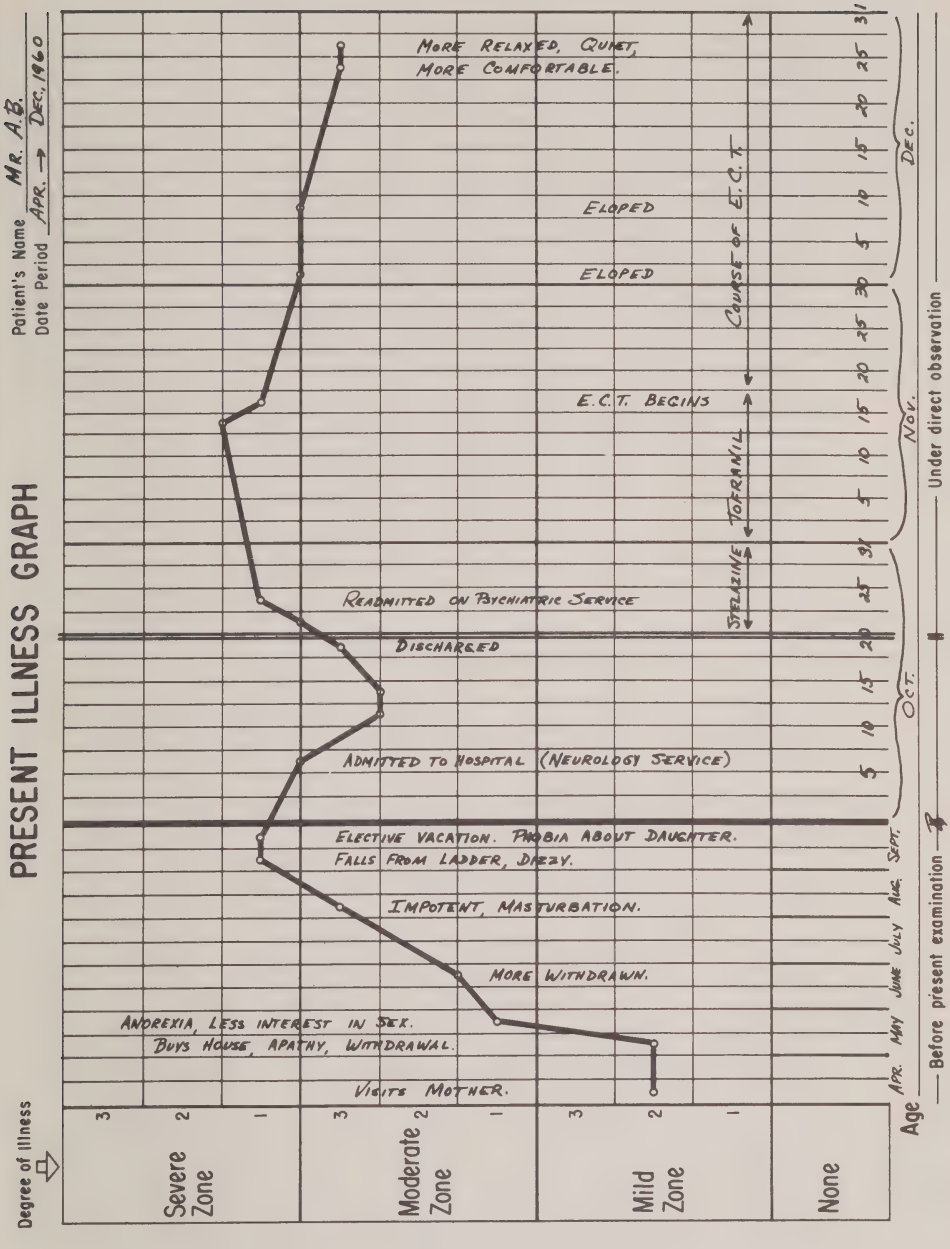

PRESENT ILLNESS GRAPH
Patient's Name MR. A.B.
Date Period APR. → DEC., 1960
Degree of illness
Severe Zone
Moderate Zone
Mild Zone
None
3
2
1
MORE RELAXED, QUIET, MORE COMFORTABLE.
ELOPED
ELOPED
COURSE OF E.C.T.
E.C.T. BEGINS
TOFRANIL
STELAZINE
READMITTED ON PSYCHIATRIC SERVICE
DISCHARGED
ADMITTED TO HOSPITAL (NEUROLOGY SERVICE)
ELECTIVE VACATION. PHOBIA ABOUT DAUGHTER. FALLS FROM LADDER, DIZZY.
IMPOTENT, MASTURBATION.
MORE WITHDRAWN.
ANOREXIA, LESS INTEREST IN SEX. BUYS HOUSE, APATHY, WITHDRAWAL.
VISITS MOTHER.
APR. MAY JUNE JULY AUG. SEPT. OCT. NOV. DEC.
Age
5 10 15 20 25 31 5 10 15 20 25 30 5 10 15 20 25 31 5 10 15 20 25 31
— Before present examination
— Under direct observation
MF-560 (3-62)

FIGURE 7

DAILY CLINICAL FLUCTUATIONS GRAPH

Patient's Name MR. A. B.
Date Period Nov. 23, 1960 to Dec. 23, 1960.

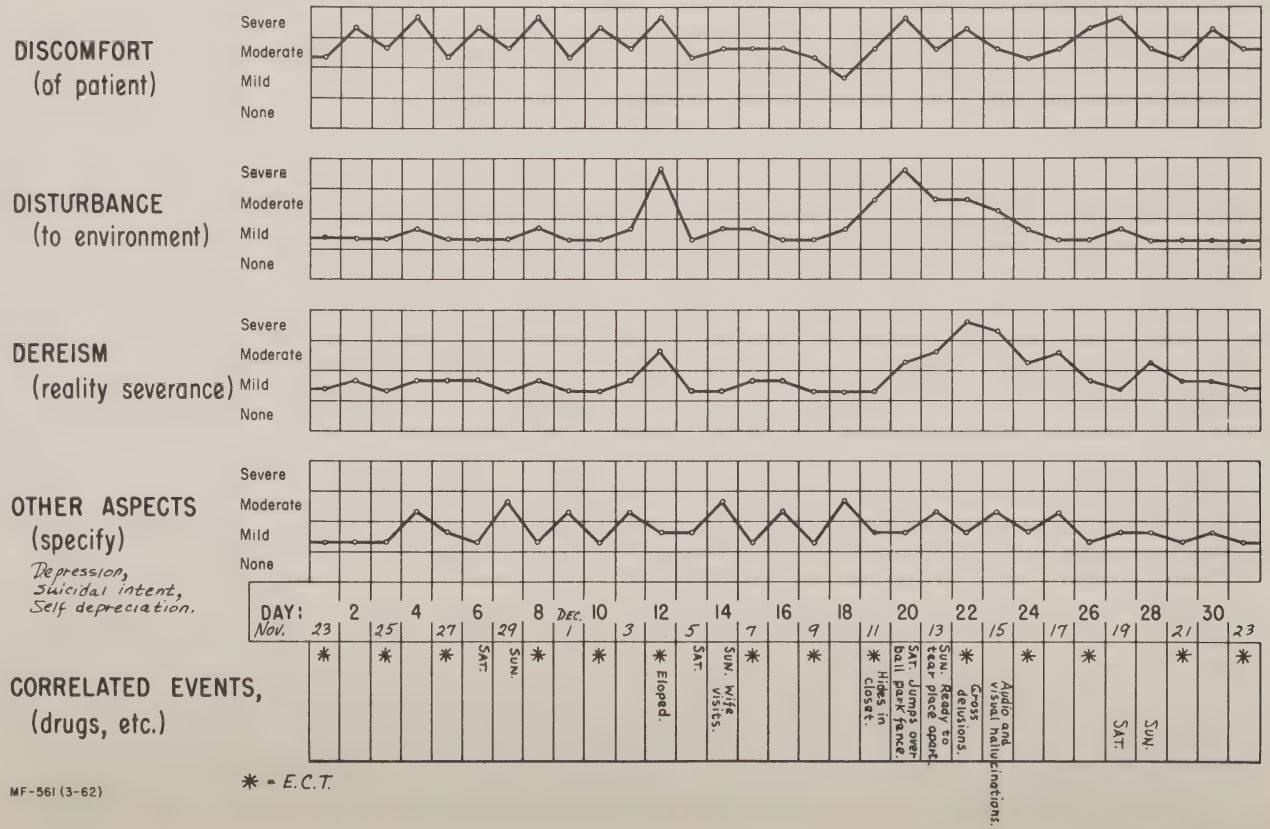


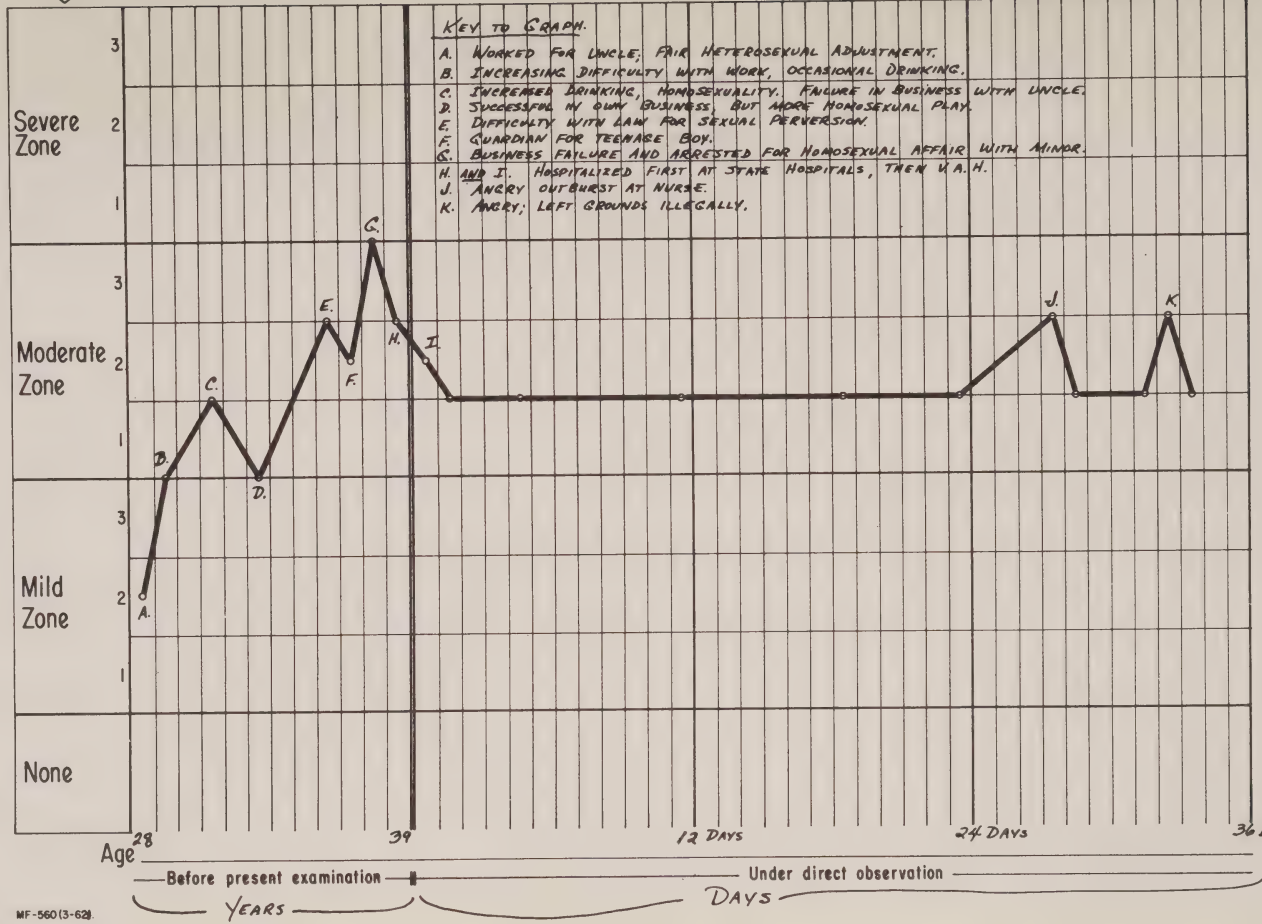
FIGURE 8

MF-561 (3-62)

PRESENT ILLNESS GRAPH

Degree of Illness

Patient's Name MR. C. D.
Date Period SEPT. 1945 – OCT. 12, 1960



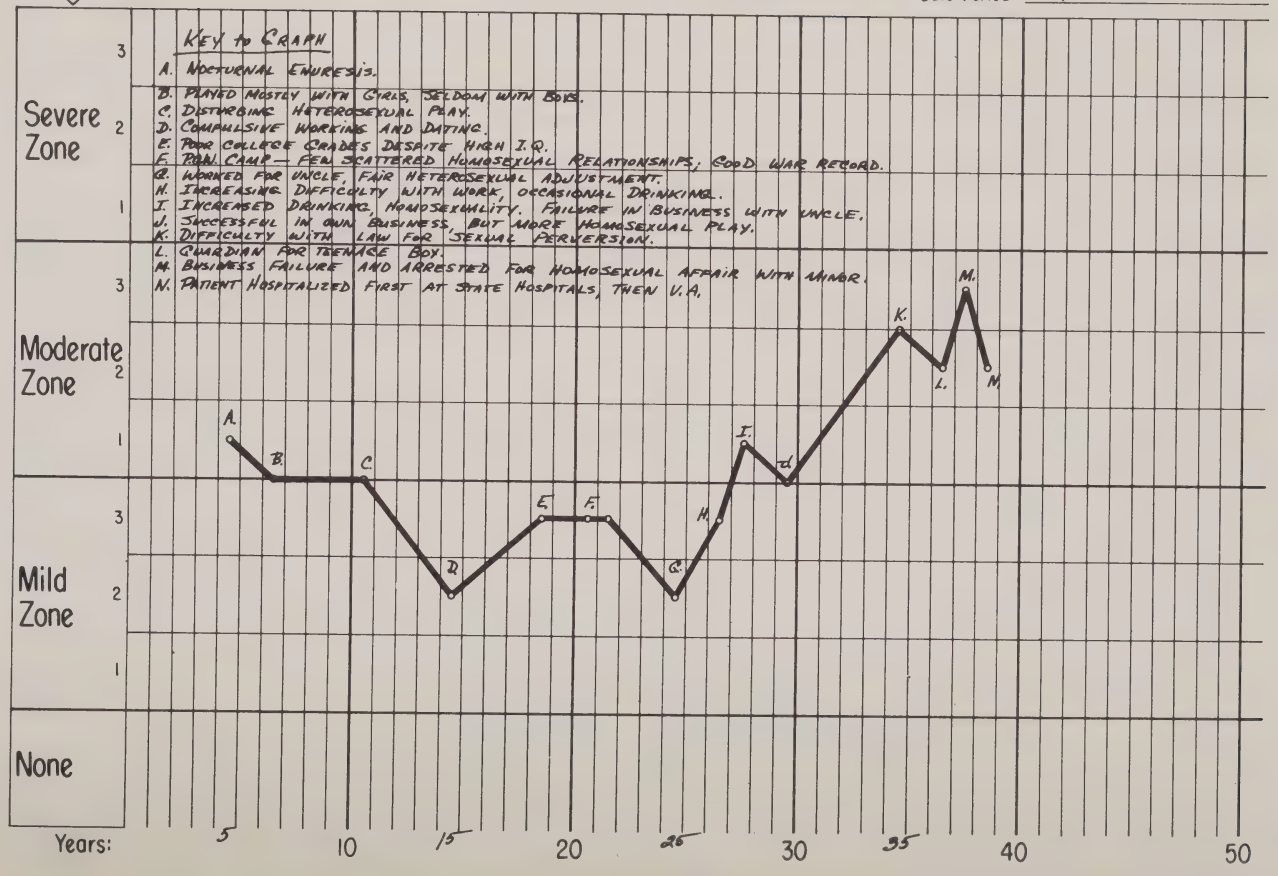
MF-560 (3-62)

FIGURE 9

LIFE COURSE GRAPH

Degree of illness

Patient's Name MR. C.D.
Date Period 1921-1960



KEY to GRAPH

A. NOCTURNAL ENURESIS.
B. PLAYED MOSTLY WITH GIRLS, SELDOM WITH BOYS.
C. DISTURBING HETEROSEXUAL PLAY.
D. COMPULSIVE WORKING AND DATING.
E. POOR COLLEGE GRADES DESPITE HIGH I.Q.
F. P.O.W. CAMP — FEW SCATTERED HOMOSEXUAL RELATIONSHIPS; GOOD WAR RECORD.
G. WORKED FOR UNCLE, FAIR HETEROSEXUAL ADJUSTMENT.
H. INCREASING DIFFICULTY WITH WORK, OCCASIONAL DRINKING.
I. INCREASED DRINKING, HOMOSEXUALITY. FAILURE IN BUSINESS WITH UNCLE.
J. SUCCESSFUL IN OWN BUSINESS, BUT MORE HOMOSEXUAL PLAY.
K. DIFFICULTY WITH LAW FOR SEXUAL PERVERSION.
L. GUARDIAN FOR TEENAGE BOY.
M. BUSINESS FAILURE AND ARRESTED FOR HOMOSEXUAL AFFAIR WITH MINOR.
N. PATIENT HOSPITALIZED FIRST AT STATE HOSPITALS, THEN V.A.

MF-559 (3-62).

FIGURE 10

CHAPTER VII

The Case Summary

THE PSYCHIATRIC CASE STUDY comes to a logical termination when, from the analysis of the collected data, the diagnostic conclusions reached are such that a treatment program can be prescribed and a prognostic estimate offered. At this point the record file will then contain the following raw data:

1. Pertinent correspondence
2. Historical data obtained from various sources
3. Examinational data—physical, neurological, laboratory, psychological and special (EEG, X-ray, etc.)
4. The initial tentative program of treatment and subsequent modifications, if any
5. Progress notes regarding the course of illness as observed since admission, the patient's response or lack of response to treatment, complications, consultations, etc.
6. Graphic charts of the course of illness based on 2 and 5 above
7. If the patient has been discharged, a discharge summary; if the termination was by death, an autopsy report

The examining psychiatrist will have come to certain conclusions regarding the diagnosis, prognosis and program of treatment, and he will have recorded some of the latter in prescriptions, nurses' orders, referrals and so on.

But while steps have been taken to initiate treatment, steps must also be taken to organize the data and the conclusions based upon them for the various purposes to which they will be put sooner or later, including the revision or extension of the treatment. It may be desirable to submit the summary of a case to a consultant or a colleague. It is always in order to inform the referring physician or agency of what has been found, what has been done, what is expected and what is recommended. Courts of law and boards of adjudication must make decisions based on the reports submitted to them by those who make the case studies. Nurses, social workers and others need over-all information about patients in whose treatment management they are participating. In a teaching hospital,

case studies are regularly "presented" to a group of colleagues by the examining physician.

For each and all of these purposes, a condensed digest of the material is essential. Such a summary should not only convey the conclusions reached, but cite the essence of the data upon which those conclusions were based. Both brevity and clarity are important. The specific purpose of the particular summary should be stated, because this will determine in some degree the content and in some instances the wording of the summary (*e.g.*, such expressions as "ego strength" and "anal sadism" are pardonable in a summary made for a psychoanalytic colleague, but such jargon is useless and actually prejudicial in a summary directed, for example, to a judge or a surgeon).

Outline for Summarizing the Case Study

The following outline defines the form in which data and conclusions are organized for presentation to staff conferences in the Menninger School of Psychiatry. It is used in all of our participating hospitals and clinics. This is true whether the case study has been completed or is only in the process stage—for example, as at the time of the so-called Diagnostic and Appraisal Conferences. Depending upon the use to which the summary report will be put, various items may be appropriately condensed or expanded, but in almost no case should it require more than four or five single-spaced typewritten pages—for example, about two pages for the administrative and clinical data, a page for the diagnostic and prognostic conclusions and a page for the treatment recommendations. The most important items are III.B., III.C., and IV.

I. Administrative Data

A. Name or file number, age, sex, nationality, ethnic group, marital status, occupation, religious affiliation and place of normal residence

B. Referring physician or agency

C. Administrative status of patient at time of this summary

D. Purpose of this summary, and date of preparation

II. Clinical Data

A. *Historical data*

1. The "chief complaint," the presenting symptom or events leading to the initiation of the psychiatric case study.
2. The background of the patient's life, with selected data from the family, childhood, developmental, sexual, occupational and military history; a condensed account leading up to the present illness.
3. The present illness; a brief review of the events, external and internal, which led to the making of the case study, with sources.

B. *Examinational data*

List or describe the significant findings from the:

1. Physical examination, with date
2. Neurological examination, with date
3. Laboratory, X-ray and special examinations, with dates
4. Psychological examination, with date

C. *Observational data*

Changes which have occurred since the above data were collected, including tentative treatment procedures and observed responses thereto. These data may be omitted if the interim has been very short.

III. Diagnostic and Prognostic Conclusions

A. *Appraisal of the environment*

1. The general environment of the patient's life adjustment (national, social, economic, geographic, etc.)
2. Characteristics of the more immediate environment (neighborhood and family)
3. Environmental factors particularly injurious or over-stimulating to the patient or particularly supportive to him
4. Injuries to the environment by the patient, and its reactions thereto; also any particular contributions to it from the patient

B. *Appraisal of the patient*

1. *Somatic* structure, functions and reactions
   a. Special assets (physical, physiological, neurological)
   b. Impairments (use standard nomenclature and give date)
2. *Psychological* structure, functions and reactions
   a. Assets and potentialities (sublimations, talents, intelligence, etc.)
   b. Impairments and liabilities

(1) Pre-clinical (predisposition, personality disorder, etc.; use APA designations)
(2) Present disorganization
(a) Degree (mild, moderate, severe)
(b) Type (acute, chronic, episodic, recurrent)
(c) Trend (increasing, decreasing; slow, fast)
(d) Syndrome (most nearly appropriate APA designations)
(e) Symptoms and signs (list, or refer back to psychological examination summary)

C. *Explanatory formulation* (genetic, developmental or dynamic)

D. *Prognosis*
1. Probabilities regarding the further trend of the disorganization with and without therapeutic intervention (listing, if helpful, the determining forces pro and con)
2. Accessibility of the patient to treatment (motivation, cooperation, economics, etc.)
3. Possibilities of changing the environment in a favorable direction

IV. Treatment Recommendations

A. *Initial arrangements*
1. Place (home, hospital, office, etc.)
2. Legal status
3. Economic arrangements
4. Attitudes of patient and relatives toward treatment

B. *Somatic Therapy*
1. Medicinal (drugs, dose, frequency, purpose)
2. Physical (type, frequency, purpose)
3. Dietary (type, purpose)
4. Dental (specify)
5. Special (*e.g.*, ECT)

C. *Psychological Therapy*
1. Psychotherapy (type, frequency, therapist)
2. Counseling (educational, religious, vocational, marital, general—where and by whom)
3. Group psychotherapy, psychodrama, group projects
4. Extramural resources (church, schools, AA)

D. *Milieu Therapy* (Controlled Therapeutic Environment)
   1. Type of control required (hospital, school, day hospital, etc.)
   2. Prescribed attitudes of milieu personnel toward patient
   3. Milieu living arrangements; instructions to nurses concerning:
      a. Contacts with aides and nurses
      b. Contacts with other patients
      c. Precautions against special dangers
   4. Living-Learning program within the milieu:
      a. Industrial
      b. Educational
      c. Recreational
      d. Creative
   5. Extramural contacts (stipulations regarding telephone calls and visitors—with whom, whom not, frequency and duration)
   6. Contacts with physician (frequency, duration, technique)

E. *Separation Planning*
   1. Casework with relatives during patient's treatment (specify persons, aims, emphasis)
   2. Conditional factors preventing, limiting or impelling discharge of patient
   3. Projected program of discharge steps (passes, trial visits, halfway house, day hospital, another hospital, another clinic)
   4. Recommendations already apparent regarding discharge: e.g., changes necessary in environment, treatment by another agency, ultimate referral to colleagues, etc.

V. Addenda (where time has elapsed since preparation of summary)
   A. Subsequent developments, responses, complications
   B. New information about patient or environment
   C. Radical changes in external situation
   D. Opinions and recommendations of consultants

RECAPITULATION OF THE MAIN TOPICS OF THE CASE STUDY SUMMARY

I. *Administrative Data*
   - A. Name, age, sex, etc.
   - B. Referred by . . .
   - C. Administrative status
   - D. Purpose and date of summary

II. *Clinical Data*
   - A. Historical
   - B. Examinational
   - C. Observational

III. *Conclusions*
   - A. Environment
     1. General
     2. Immediate
     3. Injuries *to* patient
     4. Injuries *by* patient
   - B. Patient
     1. Somatic
        a. Assets
        b. Pathology
     2. Psychological
        a. Assets
        b. Pathology
           (1) Preclinical
           (2) Present
   - C. Explanatory formulation
   - D. Prognosis
     1. Environment
     2. Patient
     3. Timing

IV. *Treatment*
   - A. Initial arrangements
   - B. Somatic therapy
   - C. Psychological therapy
   - D. Milieu therapy
   - E. Separation planning

V. *Addenda*
   - A. Subsequent developments
   - B. New information
   - C. External situation
   - D. Consultants' opinions

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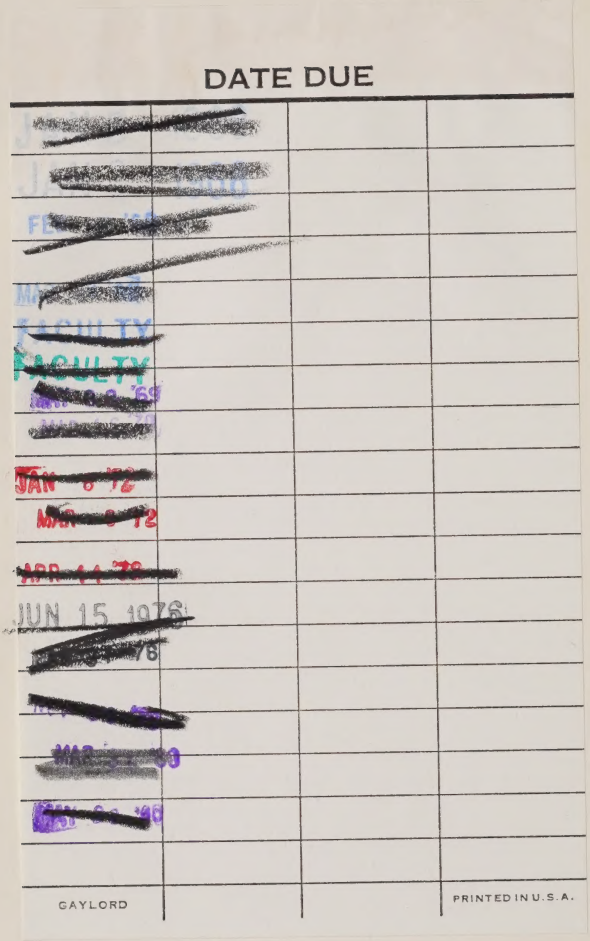
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